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The Christmas Spirit

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THE Birthday of our Lord and Saviour, Jesus Christ, year after year brings with it the wistful charm of the wintry stable that irresistibly appeals to the human heart. The melodious and familiar strains of the "Adeste Fideles" ring out the same glad message, the good tidings of great joy, summoning all the faithful to come with hearts all joyful to Jesus in Bethlehem. This feast of the Incarnation more than any other seems to knit closer together the hearts of men in that common faith that draws man closer to God, earth closer to Heaven, and Heaven nearer to earth, for this great mystery of the Incarnation bridges that great gulf between God and His creatures by establishing a more intimate relationship between man and his Creator.

On the first Christmas night as the glory of God lit up the darkening sky, angel voices sent from Heaven brought comfort and divine hope to men. Over the bleak hills of Bethlehem resounded the happy message, "Glory to God in the highest and on earth peace to men of good will." The silvery cadence of that angelic hymn has floated over the world for centuries. Serene and sweet and strong it has been heard by countless millions, and will be heard by millions yet to come, silencing the clamor of conflict, bathing hearts in love, and drawing all men to the crib of Bethlehem, "to the place where God is homeless, and all men are at home."

That blessed night opened up for the world a new era, fulfilled the ancient prophecies, and gave to mankind a Saviour long expected by the nations. The tidings of great joy announced by the angels to the shepherds that "this day is born to you a Saviour, who is Christ, the Lord in the city of David," were the spiritual basis upon which the first Christmas observances were founded, and upon which every subsequent Christmas celebration should be founded. Because Christmas is our Saviour's Birthday is the reason of all the joy and happiness we bring to its celebration. The human peace of this season, the feasting, the gladness, the kindliness, and the charity toward others, all grow out of a deeper joy.

But the real Christmas spirit must be built upon something more lasting than a foundation of human kindliness and good fellowship. Had this materialistic conception of Christmas been the motive power behind the age-old observance, this greatest festival in the year would have long since passed like an iridescent thing of beauty, too frail to withstand harsh contact with the world, and too tenuous to live amid the turbulent currents stirred up throughout the ages by man's inhumanity to man.

This Christmas spirit must be the spirit of a true Christian, who regards Christmas as the day on which Christ our Lord came into this world not as a conquering hero or as a mighty monarch in a blaze of splendor. No! But emptied of all the heavenly majesty that fills the angels of light with awe, and bereft of all the mighty power that makes the angels of darkness tremble, He came in the form of a little helpless infant, born of a Virgin Mother, wrapped in swaddling clothes, and laid in a poor manger, surrounded not by the haughty and proud ones of this world, but by His humble and saintly Mother Mary and His Foster-father St. Joseph, by the simple shepherds from their lonely watches on the hillsides of Bethlehem, and by the dumb beasts of the field. In His advent to us, He would not fill us with fear, but inspire in us love and humility and hope. This, indeed, was a plan of redemption worthy of God, and one that only a God could execute. This was charity infinite and sublime, the love of God yearning for a closer union with mankind, that He might bring man back to the arms of his Creator.

The true spirit of Christmas must also be based upon a firm belief in the Divinity of Christ Our Lord. And Christmas time is an opportune season to make a profession of our faith in the Divine nature of Christ incarnate. Such a profession of faith is most fitting in these days when so many ill-inspired men are making melancholy efforts to rob Christ of His divine attributes and reduce Him to the stature of mere man. When we come to the crib of Bethlehem we do not stand. We kneel reverently and adore, because we believe that the

Child, Who has been born to us comes from Heaven not in a figurative sense, but in a real sense. He is Eternal. He is God. He is now, indeed, clothed in human lowliness, but He has forever been clothed in divine majesty. The splendor of His Divinity is hidden to our mortal eyes, but it is visible to the angels, who bow before Him in worshipful silence, and adore Him as they adore at the throne of the Most High. Let no one, then, think that he can grasp the innermost meaning of Christmas, and that he can share its ecstatic joys, if he does not unequivocally accept the plain doctrine of the Divinity of Christ our Saviour.

Therefore our earnest wish and hopeful prayer at this Christmas season for all the readers and friends of Hospital Progress are that they may receive a greater increase of strong and practical faith in the Divinity of our Lord, and that their hearts may be moved to a greater love of God and their neighbor by the example of Christ's boundless charity. With these virtues deeply rooted in our hearts may those, who conduct institutions for the unfortunate and afflicted of God's creatures, imitate Him Who, during His lifetime on earth, "went about doing good; healing the sick, making the blind to see, the deaf to hear, the lame to walk and cleansing the leper." May those good and faithful men, who make it their life-work to care for God's sick and disabled, by a deeper faith in Christ, the Great Healer, derive from Him the strength and courage and knowledge that will increase the efficiency of their noble work. And may our devoted nurses be imbued with the spirit of Christ's divine charity that they may unselfishly fulfill the sacred duties of their humane calling. And finally may our Hospital-Calvaries become Thabors with the sunshine of God's love beaming upon them, and the grace of His bounteous benediction descending upon our Christian work. This Christmas wish may well be epitomized in the words of the collect of the second mass for Christmas day: "Grant, we beseech thee, O Almighty God, that, as we are enlightened by the new light of Thy Word made flesh, we may show in our actions the effects of that faith that shineth in our minds."

Holiday Greetings

Rev. Edward F. Garesché, S. J.

A MERRY CHRISTMAS and a HAPPY NEW YEAR! The dear old greeting cheers the cockles of our hearts, year after year, at the holiday season and never loses a particle of its congenial friendliness. From the depths of our hearts, we utter it once again to all who read these pages, to the Sisters in our hospitals, to the patients, to the staff, the nurses, the students, all the workers, all the visitors and the guests. May Christmas merriment and New Year's happiness abound and overflow in each one's soul.

Christmas and the New Year come close together. They are linked in sweet festivity, in holy memories. Christmas is the feast of Christ's nativity, when the Word made Flesh came to dwell among us. New Year's is the Feast of His circumcision and a day consecrated to thankfulness for the old year and hope for the new. Both feasts have singular significance in the quiet walls of the hospital.

The Feast of Christmas is also the birthday of Christian charity. Before the little Infant lay in the manger and stretched His baby hands to embrace mankind, Christian charity was unknown in the world. Christmas is the feast of the birth of that love which has built modern hospitals. When Christ was born, there was born also the inspiration of all the good deeds, the acts of mercy and kindliness, the help and the healing, which our hospitals offer to mankind.

We bid each other be merry at Christmas. Merriment means mirth, cheerfulness, and gay spirits. It means happiness and laughter, joyfulness and cheer. Of all birthdays, Christmas is the merriest because Christ's coming was the most fortunate and happy thing that ever happened on this earth. We wish to all our hospitals an abundant share of this glad rejoicing and we wish them, too, the greatest measure of that Christian charity which can alone give the truest joy.

We wish you all in like manner a Happy New Year. The merriment of Christmas belongs peculiarly to that holy season, and it cannot be captured at any other time of the year. But happiness is an enduring thing, tranquil, gentle, and lasting. It does not depend on pleasure, it can coexist with pain and labor. To be happy is to be content and at peace, and there is much happiness in the daily life of the hospital.

But just as the merriment of Christmas comes from Christ, so does the happiness of the New Year. We are happy in Him, for Him, because of Him. We are brothers and sisters of God, because He has become a Man. What an unfailing spring of happiness in that thought!

In the hospital we live with Christ, we work for Christ, Christ is our daily company. He is within us and without us. He feeds us and sustains us and yet in the persons of His sick brethren, He allows us to minister to Him and He depends on our ministry. His living images are all about us. Every word we utter is uttered to His representatives, every action we perform, He takes as done to Him, if it is offered for His love.

Oh, great, silent multitudes of hospital workers, to whom, each month, Hospital Progress goes forth as a

message for Christ, we greet you, and we wish you the Merry Christmas and the Happy New Year which come from being near and dear to Him. May you love Him very dearly. May you serve Him very faithfully the live-long year. He will comfort your afflictions. He will console your sorrow. He will make your work fruitful. He will love you and cherish you with the endless tenderness of His most divine and still most human Heart.

You are, for the most part, a silent multitude, but now and again, from the midst of your exacting labors, some message comes, some echo of appreciation reaches us. To you in particular, kind and generous friends, who always respond to every message, who always second every effort, on whom we chiefly depend for encouragement and cheer, to you we send a special greeting. Those who are wrapped in silence remain so, no doubt, because of many preoccupations, and, therefore, we still love them and greet them. But to our special friends we must send a special message. To all, then, but to you in particular, dear helpers and encouragers, we wish a Merry Christmas and a Happy New Year.

Greetings From The Hierarchy

My most sincere Christmas greetings to the Catholic Hospital Association, all its officers, and members. May the Divine Savior, whose infinite love brought Him from the heavenly throne to the lowly crib of Bethlehem, fill the hearts of the members of the Catholic Hospital Association with the fire of holy charity towards all their suffering fellow men.

✠ *S. G. Messmer,*
Archbishop of Milwaukee.

In reply to your kind letter of Nov. 19, asking for "a line of greeting" for HOSPITAL PROGRESS, I am pleased to say that HOSPITAL PROGRESS is doing a most excellent work in behalf of our Catholic institutions for the relief of suffering humanity. Its success in elevating the standards and morale of our institutions in the past has won for it a place of prominence among the publications devoted to the charitable and humanitarian cause of relieving suffering. I have no doubt that the future will see it even more successful in its noble mission. God bless and prosper HOSPITAL PROGRESS and all those associated in its publication!

With kindest regards, I am yours sincerely in Christ,

✠ *J. W. Shaw,*
Archbishop of New Orleans.

Dear Father Garesché:

Even from Alaska let a voice reach you at this festal season which brings you messages of appreciation and good wishes from the breadth and length of our continent.

The benefits of encouragement and standardization which the labors of the Catholic Hospital Association and the cooperation of its friends have imparted to our Catholic institutions for the sick, have made themselves felt here and given cheer.

We thank you and wish you that the year 1927 be one of growing success in all the spheres embraced by your activities.

On, then, to still vaster achievements by the grace of God and the power of daily advancing science, together with the stimulation that comes from the joy of great good accomplished and from the ambition of greater good in sight.

May He, Who came on the first Christmas to give start, increase, and fruitage to that blessed work of Mercy of which your association is the persuasive exponent and the glorious champion, shower blessings upon blessings for the realization of your ideals of service through the new year.

Such is, on behalf of Alaska, for the officers and friends of HOSPITAL PROGRESS, the fervent greeting and earnest prayer of,

Yours most sincerely in Our Lord,

✠ *J. R. Crimont, S.J.,*
Vicar-Apostolic of Alaska.

While for very good reasons I have little or no acquaintance with the science of medicine, I am, nevertheless, in common with every Bishop and all sympathizers with suffering humanity, grateful to God for the very numerous excellent institutions caring for ills to which poor human nature is heir.

Our hospitals, in general, are keeping pace with the truly wonderful advance of medical science. For this fact great praise is due to the Catholic Hospital Association of the United States and Canada. In the comparatively few years of its existence it has obtained results which have placed our hospitals in the front rank of similar institutions throughout the country. Our Sisters' hospitals in the United States and Canada are now taking care of some five million patients a year. Their four hundred schools of nursing are sending out each year thousands of graduates. What a blessing for poor suffering humanity!

All praise likewise to our devoted Sisterhoods who spend their lives in so noble a cause! May God continue to bless the Catholic Hospital Association, our hospitals, and the self-sacrificing women who serve them.

Yours sincerely in Christ,

✠ *Edward J. O'Dea,*
Bishop of Seattle.

At this season I am very pleased to send a word of greeting to the editorial staff of HOSPITAL PROGRESS. Your splendid publication is, I am sure, a great help to our good Sisters who are engaged in the care of the sick. The articles are well written and timely and furnish interesting reading for the public in general as well as for those engaged in hospital work.

Wishing you all the graces and blessings of this holy time, I remain,

Sincerely yours in Christ,
✠ *Edmund Heelan,*
Bishop of Sioux City.

I am very glad to offer through you to the Catholic Hospital Association membership my most sincere wishes for a very blessed Christmas season.

I know of no agency that is daily doing more to bring the peace and joy of Christ to the children of men than our hospitals. I sincerely hope that the Infant King of the Human race will bless abundantly those who willingly and generously provide a place of shelter to those who, like Him, can find no room elsewhere.

With every good wish for a very happy Christmas to all our hospital Sisters, their assistants, and their patients and a New Year full of promise of even greater achievements.

Yours very sincerely in Christ,
✠ *John B. Morris,*
Bishop of Little Rock.

The charm of Christmas never palls. Its recurring wonder is ever fresh and new. Indeed it grows fresher and stronger as grow our years and we learn more and more of "the goodness and kindness of God our Savior" who for our sake and for our salvation came down from Heaven and became a little child.

Christmas is the Feast of God's wondrous love for men. In the Scriptures astonishing words are applied to Eternal Wisdom, the Word of God. He declares, "My delights are to be with the children of men." Who could have believed it? He dwells in light inaccessible; He possesses all the riches of the divine perfection; He enjoys the fullness of life and beatitude; and yet He declares that to be with the children of men is for Him a delight. And so "the Word was made Flesh and dwelt among us!" O happy, holy Christmas night! On that night "a Child is born to us and a Son is given to us." That Child, the Son of Mary, is also the Son of God—and our Emmanuel, our Savior, our Liberator.

And how "copious is His redemption!" "He became to all who obey Him the cause of eternal salvation." "God so loved the world as to give His only-begotten Son." Christ's "emptying of Himself" has enriched us exceedingly. His humiliation has exalted us to the dignity of the children of God. It is through Jesus that we receive the divine adoption: "God sent His Son, made from a Woman, that we might receive the adoption of sons." We are exalted by grace to what He is by nature. Through Christ's love for us we enter into God's family. "We are sons of God, and if sons, heirs also—heirs indeed of God and joint heirs with Christ." What dignity is this! What a privilege is ours!

Christmas is the birthday of our Divine Elder Brother. It is meet and just that we rejoice and in "psalms and hymns and spiritual canticles sing and make melody in our hearts to the Lord."

✠ *John B. MacGinley,*
Bishop of Monterey-Fresno.

I sincerely congratulate you on the splendid work you are doing in HOSPITAL PROGRESS. Permit me to use this opportunity to wish all my fellow readers of HOSPITAL PROGRESS a most blessed Christmas. I shall appreciate gratefully a copy of "The Patient's Book."

Devotedly yours in Christ,
✠ *Wm. T. Russell,*
Bishop of Charleston.

I am very happy through the columns of HOSPITAL PROGRESS to extend my best wishes to that great group of people who have come to know that life is not all roses, and whose days are not altogether filled with sunshine. I pray that Almighty God may bless them all, and teach them the way to turn the afflictions of life to their spiritual profit. It is easily possible that people, afflicted as they, can be very happy, much happier sometimes than those whose souls are sick while their bodies are wholesome.

Sincerely yours in Christ,
✠ *Hugh Boyle,*
Bishop of Pittsburgh.

At the approach of the gladsome feast of Christmas and the beginning of another year I extend my most cordial greetings to the editor and readers of HOSPITAL PROGRESS, with the sincerest wish that this most excellent magazine may, under God's blessing, continue its splendid and most useful work among an ever wider circle of interested readers.

I will be glad indeed to receive a copy of "The Patient's Book."

Most sincerely yours in Christ,
✠ *C. Van de Ven,*
Bishop of Alexandria.

To you and to all interested in the PROGRESS of our hospitals I send heartfelt Christmas greetings. May Christ our King, who came to bear our weakness and our infirmities, give to you all engaged in His work of mercy every best gift and every perfect gift at Christmas tide.

Praying a special blessing upon you, dear Father, I am always devotedly yours,

✠ *Edward J. Hanna,*
Archbishop of San Francisco.

The glorious work being done in our Catholic hospitals is well reflected in the bright pages and helpful articles of HOSPITAL PROGRESS. This progressive publication not only brings all our hospitals into closer touch with each other, but also stimulates the work in every department of each hospital.

Assuring you of my blessing and best wishes for the coming year, I beg to remain, as ever, fraternally yours in Christ,

✠ *Aug. J. Schwertner,*
Bishop of Wichita.

Let me assure you, dear Father Garesché, of my appreciation of the work being done by the Catholic Hospital Association and your valued periodical, HOSPITAL PROGRESS. I shall be grateful for any literature that you may send me.

With kindest wishes and every blessing on your splendid work, I am

Very sincerely yours in Christ,
✠ *Daniel M. Gorman,*
Bishop of Boise.

Dr. Martin's Greeting

To the Catholic Hospital Association and HOSPITAL PROGRESS my every wish for a happy Christmas season, and unbounded success during 1927. May your leader and President, the Reverend Charles B. Moulinier, S. J., be spared for many years to continue his splendid and noteworthy work.

Franklin H. Martin, M.D.,
Director Gen., Am. College of Surgeons.

We wish all of those connected with HOSPITAL PROGRESS a very joyful Christmas replete with many blessings from the Divine Babe and every success for the New Year.

Sisters of Charity,
St. Vincent's Hospital, Leadville, Colo.

A New Year's Message to the Catholic Hospital Association from the American College of Surgeons

Malcolm T. MacEachern, M.D., Associate Director, American College of Surgeons.

ONE more year with its accomplishments passes on as part of a great drama in the relieving of pain and suffering, the prevention of disease, and the saving of human lives. These are worthy and noble objectives. Though the results may not be apparent to all, nevertheless they have been accomplished silently and unassumingly if our hospitals are actuated by the right spirit, or the spirit of service. Sometimes in the great hustle and bustle of life these things are overlooked. Perhaps it would be well for us to pause a moment and take an inventory of our accomplishments. This may be a guide in the year of 1927, which opens up a new field of three hundred and sixty-five days rich with opportunities to serve our best. Each hospital, at the beginning of the year, must set its compass right and aim for the goal which should be *the best care possible of the patient.* Better to insure this each Sister Superior charged with the responsibility of directing a hospital must constantly ask herself:

1. Is my hospital physically safe and adequate to give the patient proper care?

2. Has my hospital a competent personnel, imbued with the lofty ideals of service that insure the patient the right kind of care?

3. Is my hospital properly organized and coordinated in its various departments to give the patient prompt and efficient service in the most economical manner?

4. Has my hospital an ethical, competent, carefully selected medical staff which meets regularly every month or oftener thoroughly, frankly, and scientifically to analyze and appraise the professional work?

5. Has my hospital intelligent, clear-cut rules and regulations governing its administrative and professional policies, setting forth duties, functions, and responsibilities?

6. Has my hospital a true, scientific case record of every patient admitted?

7. Does my hospital take the necessary precautions to prevent unnecessary and incompetent surgery?

8. Has my hospital an adequate clinical laboratory and x-ray department, under competent medical supervision, with sufficient technical staff to give the proper service?

9. Has my hospital an accredited school for nurses?

10. Has my hospital a well organized, efficient dietary department under a competent graduate dietitian, who cooperates with the hospital personnel, the clinician, and the laboratory worker?

11. Has my hospital received the approval of the American College of Surgeons?

12. Has my hospital played its part in the community health program for the prevention of disease?

Let every Sister Superior during the coming year frequently appraise her institution in the manner indicated above. In addition, continued efforts must be made by each institution to keep itself human and not get too machine-like. If we bear in mind these few rambling suggestions I feel sure that our hospitals, during the coming year, will render greatly increased service and discharge their respective obligations in the most efficient manner.

Roentgenology in the Modern General Hospital

Fred J. Hodges, M.D., Roentgenologist, St. Mary's Hospital, Madison, Wis.

CONSIDER that the first American roentgenogram was made only thirty years ago; that this accomplishment was in reality nothing more than a crude experiment; that Roentgen's discovery in 1895 was primarily one of highly technical interest to physicists only, and you may well be struck by the rapid and vigorous development of the science of roentgenology into an extremely important medical specialty. At the present time there is scarcely any branch of medicine which is not or cannot be advantageously served by the roentgenologist, and the general hospital of today must make available to patients and staff this service along with the numerous other special departments which have come into being during the last two decades.

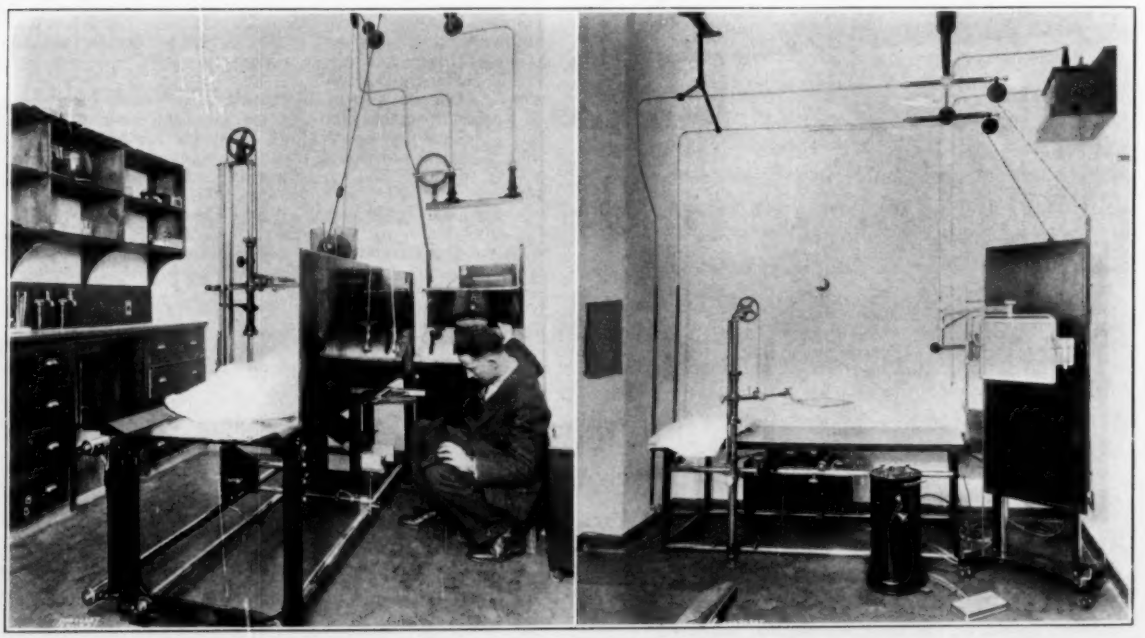
Logically, because of its more or less intimate association with all other hospital activities, the roentgen department of an institution should be carefully planned by someone trained in this field, and preferably by the future department head himself if he be qualified to do so. The selection of the location in the building, the practical and economical subdivision of the allotted space, and the purchase and advantageous arrangement of apparatus constitute a task which, though difficult and painstaking, must be done well and thoughtfully if the hospital is to be spared subsequent loss of money, or efficiency, or both.

Selection of Location in Hospital

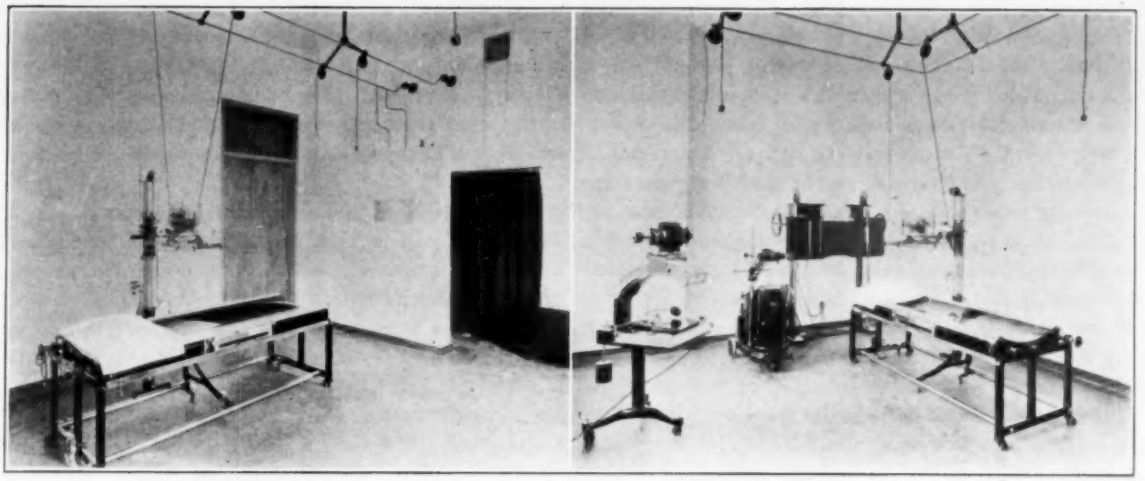
When x-ray apparatus was first placed in our hospitals, the buildings were already overcrowded for the most part, and frequently the only available space was reclaimed from otherwise unused basements. This arrangement was purely one of expediency in no wise based upon merit, but sight of this fact was lost by the builders of newer hospitals who, in modeling their buildings after older and more prominent hospitals, often copied the roentgen-ray accommodations as part and parcel of the whole, without questioning the wisdom of a basement location.

Again, the diagnostic use of the roentgen-rays has, in the none too distant past, been considered by many to be purely a mechanical laboratory procedure, undeserving of recognition as an important medical entity, and whereas no hospital superintendent would think of housing surgery, obstetrics, or business offices in a basement, roentgen workers were cheerfully consigned to such undesirable, even dangerous, quarters. There are many reasons why basement space will not serve for this type of work. The matter of moisture is the chief disadvantage. Apparatus employed in this field of diagnosis is expensive, and it deteriorates very rapidly in a moist atmosphere. In addition to actual permanent deterioration, the operation of such apparatus is rendered dangerous to technician and patient because of unlooked for short circuiting of high voltage current when air and non-conducting surfaces lose their insulating properties in the presence of water vapor. There is no habitable basement, either all or in part below grade, in which x-ray apparatus will not rust and give trouble at some season of the year.

In addition to the matter of moisture—in itself sufficient reason for condemning the basement for our



VIEWS OF THE X-RAY DEPARTMENT, ST. MARY'S HOSPITAL, MADISON, WIS. THE PICTURE ON THE LEFT SHOWS THE DOCTOR MAKING A FLUOROSCOPIC EXAMINATION BEFORE INSERTING THE X-RAY FILM FOR EXPOSURE.



VIEWS OF THE X-RAY DEPARTMENT, ST. MARY'S HOSPITAL, MADISON, WIS. LEFT: A CORNER OF THE EXPOSING ROOM. RIGHT: RADIOGRAPHIC APPARATUS WITH SPECIAL HODGES HEAD TABLE.

purpose—there is the matter of light, ventilation, and heating. Although considerable darkened space is essential in this work, the main exposing room should be light, airy, and cheerful. A high ceiling of nine to twelve feet is desirable for the proper accommodation of the high-tension system; freedom from ceiling radiators and exposed steam pipes and beams is practically essential. In a word, basement accommodations for roentgenology are, in the end, at once too expensive and too undesirable for serious consideration. The situation is truly one in which the cost of upkeep more than offsets low initial cost.

Having refused to occupy the basement, what location should the roentgenologist demand or request? The answer is dependent upon the extent of the service to be developed, as also is the amount of space required. It will be seen that if roentgenology is to be used solely in urological diagnosis, for example, the central plant should lie adjacent to the other urological space; if solely for fractures, it should form a part of the surgical floor, and so on. Assuming that a thoroughly generalized plant is required for a general hospital of 150 or 200 beds, it is well to consider every possible use to which the department may be put, and to locate it with due respect to the convenience of all interested services.

Of prime importance is elevator service, and fairly close proximity to a centrally located (not too public) elevator is essential. If the hospital in question deals chiefly with surgical cases, it will be found that the operating floor is the ideal spot for roentgenology, for here seclusion from visitors, ideal elevator service, and intimacy with the visiting staff can be had without duplication. It is necessary, under such conditions, to provide for the out-patients who will be sent in, but this can be done without great difficulty even on the surgical floor. The very great desirability of having fluoroscopic facilities immediately at hand for the surgeon in difficult fracture reductions, the necessity for close inter-relationship between surgery and roentgenology in cystoscopic examinations, and above all the opportunity for the roentgenologist constantly to improve his diagnostic ability by following cases directly to operation are all reasons for the selection of this space. It is well so to plan the roentgen service that it will be used to its capacity and to avoid the creation of conditions which will tend to limit the call made upon it.

Arrangement of Space

Location having been selected, the real problem of planning begins, for several highly specialized activities must be conveniently and economically housed. It is well to list the space requirements according to future function before attempting even a rough floor plan. For the average 200 bed hospital such a list would read about like this:

1. Entrance and waiting room.
2. Record room and office.
3. Viewing and filing room.
4. Director's office and consultation room.
5. Patient's dressing booths.
6. Roentgenography.
   (a) Exposing room.
   (b) Control booth.
   (c) Dark room.
7. Fluoroscopy.
   (a) Dark room.
   (b) Toilet (patient's).
8. Roentgen Therapy.
   (a) Exposing room.
   (b) Control booth.
   (c) Toilet (patient's).
9. Transformer space.
10. Storage.

The arrangement of these items offers an opportunity to plan in advance the circulation of patients, physicians, hospital attendants, and others, with the minimum of confusion and of unnecessary penetration into the actual working area. Every one of the items indicates a function of the department which must be accommodated in one way or another, and it is highly advisable to consider the allotment of space before, rather than after, the department begins to operate.

If a plan such as the one indicated is followed, records can be started upon the arrival of the patient at the entrance, and if it is necessary for him to wait, he

may do so without interfering in any way with the work of the department. He may, in the meantime, be seen and examined by the physician in charge, who can, from his same position, confer with physicians in the viewing room or with office help in the record room. From the waiting room the patient is shown to his dressing booth, and when ready is ushered into the exposing room, the fluoroscopic room, or the therapy quarters, as the case may be.

The main exposing room must have a separate door wide enough to admit a hospital bed, opening directly into the main corridor. This also holds true for fluoroscopy and therapy. Failure to provide for the bed or wheel-chair patient will cause great embarrassment later. The exposing room should be light and airy and of generous dimensions. A minimum length of nineteen feet will permit of great economy and convenience, as will be shown, and the width should not be less than twelve feet. A sixteen by twenty foot room is none too large, and has many advantages. It is false economy to attempt to save space in this room.

Contrary to common practice, the photographic dark room need not be large, and it will be found that a small space is very convenient, for if all walls can be reached with ease, dark room technique is simplified. It is well to have the entrance to the dark room adjacent to the control booth of the exposing room for the sake of convenience. The control booth, which is made by building a permanent plastered partition out from the wall with coating of one-quarter inch lead underneath the plaster and supplying a lead glass window at eye level, will further serve to keep the dark room entrance somewhat shaded. If it is possible to include in the dark room a small built-in electric refrigerating plant or an externally iced refrigerator, this is a desirable thing to do, in order to provide convenient facilities for preserving reserve developing and fixing solutions. A built-in cabinet with a thirty-inch top to be used as a loading bench, a pivoted film bin, and storage shelves and drawers is a valuable asset.

The transformer room is ideally located when all machines thus grouped can be joined by short direct high-tension aerial to their accessory equipment, and when noise and odor from the rectifying mechanism is reduced to the minimum. An excellent scheme, and one which is economical of space, is to deck over the dark room labyrinth (which we have already located close to the control booth), and build, in the overhead space, a transformer closet or compartment. If the dark room can be located between fluoroscopic and exposing rooms, the aerial can then be carried directly along the ceiling into each of the operating rooms. The grouping of all transformers in one room greatly simplifies the matter of bringing the main low-tension line to the transforming units. Since it is seldom necessary to enter the transformer room, it may be satisfactorily reached by way of a high outside door. When the roentgen laboratory is located on the uppermost floor of the hospital, the transformer stall may utilize a portion of the attic space.

The fluoroscopic room must be well ventilated, and if forced ventilation is available, inside space can very properly be utilized. Unless this room can be made totally light-proof, the operator will be subjected to a serious and annoying handicap. There should be running water in the room and a built-in cabinet with drawers and shelves, and conveniently located wall plugs. The cabinet will be used for the storage of linens and fluoroscopic accessories, as well as for a work bench upon which to prepare opaque media. Fairly large dimensions are desirable in order to avoid congestion and to promote ventilation, but an 8x10-foot room can be made to serve. It will be remembered that it is necessary to have in this room a door sufficiently wide to accept a hospital bed.

It is well to recall, in planning photographic and fluoroscopic dark rooms, that colored and white light with separate switch control must be provided. A convenient way to arrange these switches is to place the colored light switch at the usual level for wall switches, and those for the white light at an unusually high level, to reduce the possibility of accidental, and sometimes disastrous, sudden illumination. As a part of the fluoroscopic plan, there should be a very closely associated toilet room for the use of patients after colonic examination with the barium enema.

When possible it is desirable to separate roentgen therapy quarters from the diagnostic rooms to a certain extent, maintaining contact only through dressing and waiting rooms. It is doubtful whether short wave length apparatus for what is commonly miscalled "deep" therapy is wisely included as a part of the facilities of the average 200 bed general hospital. When this is done, special protective measures are necessary to safeguard workers in surrounding rooms. For superficial therapy there are no particular space requirements other than very adequate ventilation and a carefully shielded control booth.

Without question it is good practice to carry roentgenology to urology, rather than to attempt the surgical technique necessary in cystoscopic examinations in the roentgen laboratory itself. This can very easily be done by installing a separate transformer of small capacity in the cystoscopic room itself.

The matter of floor covering is of importance. Throughout the department all rooms in which machines are operated should be equipped with insulated floors. The most efficient and most practical way to accomplish this is to lay extra heavy battleship linoleum directly over concrete, so that the final finish is level with adjacent floors.

Selection and Arrangement of Apparatus

The amount of apparatus to be purchased depends, of course, upon the scope of work to be attempted in the particular hospital in question. The average general hospital should expect, and be equipped to do, the usual routine diagnostic procedures and a certain amount of

superficial therapy. The equipment may be exceedingly simple or very complex, but it will be found that rather complete equipment will greatly facilitate the work and improve results. Enumerating the necessary and desirable pieces of equipment, the following list will result:

1 7 or 8 inch high-tension transformer (oil immersed) including filament transformer and remote control cabinet for same (for roentgenography).
1 Fluoroscopic unit, including small self-rectified transformer and remote control.
1 10 inch oil-immersed transformer, remote control type, for superficial therapy.
1 Simple, sturdy mobile unit, self-rectified type, for bedside work.
1 Exposing table with built-in Potter-Buckey diaphragm, with electro-magnetic release and rail-mounted tube stand.
1 Upright cassette changer for chest work, also with electro-magnetic release.
1 Light weight vertical fluoroscope.
1 Horizontal fluoroscope.
(The last two items may be combined in a combination tilting fluoroscope, either motor or hand-driven.)
1 Therapy tube stand.
1 Potter-Buckey diaphragm for use with cystoscopic table.
1 Small (10x12) Potter-Buckey diaphragm for bedside use.
4 30 M. A. radiator type Coolidge tubes.
1 10 M. A. radiator type Coolidge tube.
1 Broad focus universal Coolidge tube or 1 air-cooled therapy tube.
2 or 3 Assorted cones.
4 to 6 14x17 cassettes, with double screens.
6 10x12 cassettes, with double screens.
6 5x7 cassettes, with double screens.
12 each, Paper film holders, sizes 14x17, 10x12, 5x7.
12 each, Film hangers, developing 14x17, 10x12, 5x7.
1 Thermometer, photographic.
1 Leaded film box.
1 Monolithic, three-compartment developing tank, up to 14x17 size.
2 Dark room safe lights.
1 Interval timer.
2 pr. Lead rubber gauntlets.
2 pr. Dark glasses.
2 each, Lead rubber aprons.
Film-drying rack, capacity 36 films.
1 Stereoscope with adjustable mirrors.
1 Filing cabinet, steel, to take 14½x15½ envelopes (three drawers).
1 Film view box, four 14x17 openings (Cooper-Hewitt burner desirable).
1 Film view box, 14x17, for use in operating room.
1 Set lead film numbering device.
Parts for aerial system and high-tension switches as indicated by layout.
2 Automatic time switches, hand type, for use with seven inch and bedside machines.

To this list one should add several standard texts on roentgenology, anatomy, and pathology, and an articulated human skeleton. We have found that a specially constructed table for the making of head films has greatly facilitated our work. This table makes possible exposures at a fixed tube plate distance, with fixed focus on film center in any desired angle or combination of angles through the head. The small portable Buckey listed above can be used to advantage with this table. By employing both a vertical and a horizontal fluoroscope, an orthodiagraphic attachment can be fitted to the former to permit the direct measurement of heart size, a feature of no little clinical importance.

By placing the plate changer against the wall opposite the leaded window of the control booth, and parallel with the line of vision, and separated from the plate changer by four feet, installing the radiographic table, the tube stand of the table can be made to serve for chest work, thus eliminating the necessity for an additional tube stand. This arrangement also permits of short simplified aerial and excellent vision for the operator.

It is possible of course to avoid the duplication of transformer facilities indicated in the above list by installing more complex aerial equipment, but such practice introduces the latent possibility of high-tension accidents, and the resourcefulness of the department is greatly increased when more than one transformer is available. It is a very common misconception to believe that high voltage is necessary for radiographic work, and unless some therapy is contemplated, there is no need to install a transformer capable of producing greater than a seven-inch spark gap. As a matter of fact, it is much easier for the beginner to produce first quality roentgenograms with self-rectified equipment, and by actual experiment such apparatus is found to be capable of turning out all routine work.

In the matter of actual purchase, it will be found that there are three or four well organized companies who manufacture such equipment, among whose products it is difficult and almost pointless to attempt to choose. It will be found that shopping for price alone pays no better here than in the case of automobiles, and that it is truly economical to buy the best. The total equipment listed above should not cost in excess of $7,500.

These few hints are only the ground work for the planning of a roentgen laboratory. Excellent ideas for special features are always available in current literature, and uncontrollable conditions in the individual institution will always modify the finished layout; but without some such plan of action, the architect, hospital superintendent, or roentgenologist, as the case may be, will be almost certain to overlook some of the basic necessities of the department. Unless workers in roentgenology will make an effort to make their services fully available, the mere expenditure of money for space and equipment will always fail to produce a good return on the investment so far as service is concerned.

Greetings and best wishes from St. Vincent's Hospital to HOSPITAL PROGRESS and all its readers. May God's choicest blessings descend upon all who are working to make the Catholic Hospital Association and HOSPITAL PROGRESS a success.

Sister Mary Ann, R.N.,
St. Vincent's Hospital, Los Angeles, Calif.

"A Happy New Year!" to the Catholic Hospital Association and HOSPITAL PROGRESS! May the New Year bring to HOSPITAL PROGRESS increased circulation, and to the Hospital Association choicest blessings and a generous harvest of happiness and success in its inestimable service to humanity.

Very sincerely yours,
Sisters Poor Handmaids of Jesus Christ,

Importance of Laboratory and Post-Mortem Findings[1]

Milton C. Winternitz, M.D., Dean of Yale Medical School

LET me in the first place express to you my enthusiasm over this convention that you are holding in your desire to take advantage of every possible opportunity to place your institutions in the forefront of medical progress. I am very much complimented by the honor shown me in being asked to participate. The subject that has been assigned to me is not an easy one to cover, and I have not given it very great thought at this time, but it is my life work, and I hope that I may be able to bring to you something this evening, though it may not be as well ordered as I should like.

The story of the Laboratory and its association with the hospital is the story of the history of medicine, and to summarize would require a review of the various stages through which medicine has passed from the days of the ancients, and the progress it has made. We believe that the progress made in our own particular time is the great progress. We believe however, that this particular period is one that has just gone by and one that has seen the greatest development in medicine.

Now the Laboratory first entered into importance, from the standpoint of the hospital, with the beginning of the dissection of the human body, not a very long time ago, about the sixteenth century. Over a century elapsed before any attempt was made to correlate disease, as it was found in man during his life, and as found in his body after death. Morgagni worked at a time when he had only his senses, unaided by any of the modern apparatus, to help him in the study of disease as found in the organisms. Morgagni was followed by Bischoff. Morgagni's contribution was the statement that the organs were the seat of disease, whereas Bischoff conceived tissue as the seat of disease, and Virchow conceived the cell as the seat of disease.

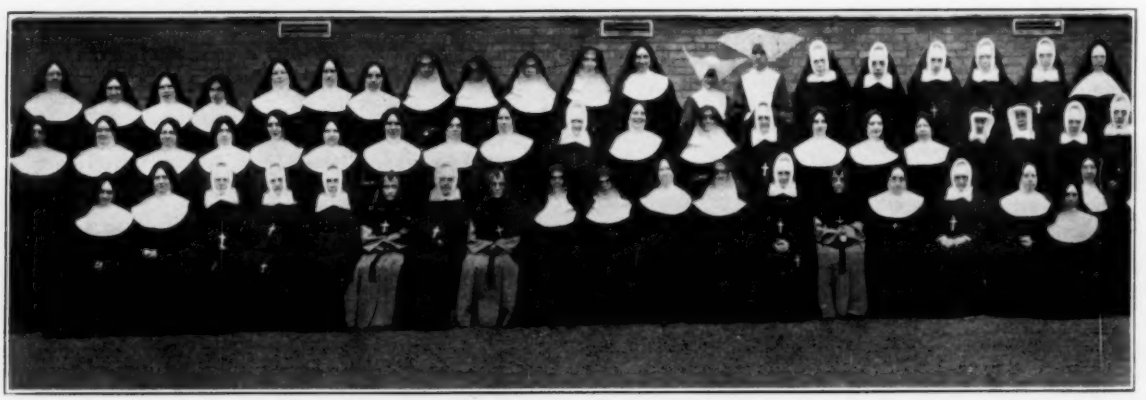
From Bischoff's time to the present, or rather until about 25 years ago, the great advancements made in our conception of disease were based upon the structural changes that occur in the different parts of the human body when they were not functioning properly. It was therefore perfectly clear that the dissection of the human body after death was the only wise way of correlating changes which occur. Bischoff, who lived in the early part of the 19th century, had a group of co-workers who followed-up every patient they had and studied them from the clinic to the post-mortem table.

In 1850, when therapy consisted of the preparation of a large number of different drugs, mixed in one way or another, and having a splendid psychological effect, medicine received its greatest setback. This was the period of therapeutic nihilism. You would be interested if you could visit distant countries to hear of the remedies that are still utilized by unsuspecting people in those regions. I remember a trip to Persia, where I found that the favored remedy for the rich was powdered pearls, and for the poor, a decoction of old shoes. A copper caldron was put on a fire, the shoes were collected from everywhere and boiled; and this was a remedy for the poor. This form of therapy, especially if the physician who prescribed it was the one who had the confidence of the patient, did a certain amount of good, which today is obtained by the modern methods of psychotherapy.

This gave way to a period of rational therapy; I mean the utilization of specific remedies for specific conditions, of which we have a few in the clinical field of therapy. We have other remedies which can be used for symptomatic conditions in the individual, but which cannot be conceived of as reaching the root of the trouble. That was the first result of the correlation of anatomical findings and from this we have progressed. The best schools of medicine have gone on with what we call rational therapy; the treatment of symptoms by specifics for those symptoms under controlled conditions.

It is perfectly obvious, of course, that after a hundred years of post-mortems, relatively little will be learned. That is, the actual increase of knowledge to

[1]Read at the New England Conference of the C. H. A.



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the world by the continuance of post-mortems has decreased almost in geometrical proportion in the past twenty-five years. But on the other hand they have another usefulness which is responsible for the perfection of rational medicine. The physician can learn to be a physician only by the correlation of clinical pictures of the disease with the anatomical findings after death. It is impossible to become a physician by reading a textbook. It is impossible to teach a student medicine, or to make a student a physician unless he actually goes through each process step by step. The process which is important is to teach the student the correlation of the disease in the patient, with the anatomical findings as seen by the naked eye, and seen in the microscope after the death of the patient.

For the teaching of medicine the laboratory is essential. We all like to be regarded as students. The hospital has a staff of physicians and these physicians must be considered students. If they have attained the stage where they can learn no more, they have passed the period of usefulness. The physician must see his patient not from without in, but from within out. He must have a picture in which he sees the functioning organs inside the patient, and in order to keep that optical quality, he must refresh himself constantly.

This can be done in the post-mortem room. He must perfect his knowledge for the benefit of the patient, who may have a type of illness that may simulate the one which was fatal to the last patient. I think, therefore, it is fair to say that the efficiency of an institution, and the efficiency of the staff of an institution is in proportion to the number of post-mortem examinations. I need not tell you that it is most necessary to have a post-mortem room. The average physician, while in school, sees only a few post-mortem examinations. When he emerges from the school the only way to continue his studies is through the post-mortem room.

It is not difficult to obtain a post-mortem. There is one thing most important; that the physician follow every fatal case using every effort to check up his diagnosis and by the autopsy and the examination of materials that may have been removed, find out how near right or wrong he was.

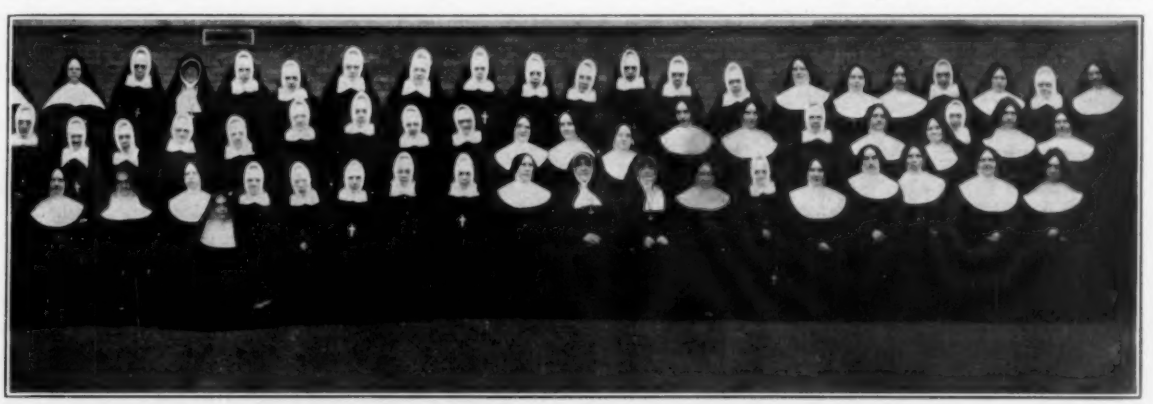
The average surgeon who is capable of conducting an operative procedure is able to make a pretty shrewd diagnosis concerning the nature of the tissue which he removes. The diagnosis is usually correct from the standpoint of the future well-being of the patient and can be checked up without much difficulty. There are cases where a surgical pathological diagnosis is necessary, of course, but they are small in number as compared to the importance of having a well-trained pathologist for post-mortem examinations. The majority of operations conducted—appendectomy, tonsillectomy, removal of glands, tumors, etc., can be diagnosed quite correctly with little difficulty, and if great experience is required it is simple enough to get a diagnosis from someone not far distant, in whom you have confidence.

You will probably raise the question of frozen sections, during the operative procedure. I believe it is a criminal thing to keep the patient on an operating table for a prolonged period of time to make a diagnosis. This I think is not a legitimate procedure. I do not believe that the best surgical pathology can be done in this way; as I have said before, it is either so simple that the diagnosis is easily determined, or it is so difficult that a pathologist with vast experience is required. Such experience is available to almost everyone because materials can be sent away.

I should not give the problem of surgical pathology anything like the same importance as the problem of post-mortem examinations. It is not so very long ago that the laboratory for the hospital was a cubbyhole in the institution with a few dozen test tubes, a bottle of acid, a bottle of Fehling's solution and a few other things. The laboratory now requires experienced people and a large equipment, in order to give your patients the proper diagnosis, the proper criteria of their condition, the proper advice concerning their future existence.

Another important field has been added—the study of bacteria, and its relation to medicine. It is a very interesting one. The knowledge of bacteria is rapidly increasing and will continue to increase for some time.

Great fields of science have been introduced in medicine, and there are some diseases that can be helped tremendously. We are working today towards the deter-



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mination of the factors of safety of the individual; not what we would do after he had diabetes but what precautions to take before he has diabetes. We are just beginning to realize that we can do so little for them that we must find out what they must do for themselves to avoid sickness. That kind of medicine requires much more knowledge and that is the work of the future for which more elaborate laboratories are needed; more complex analyses will be demanded than are required now when there is already manifestation of disease which indicates itself by some symptoms in the individual. This will not be attained at once. We are going to work hard toward preventive medicine. We have done a great deal towards it in the past decade or two. It is a great satisfaction to the doctor to be able to tell a patient—"You have heart disease"—but it is not a satisfaction to the patient to be told he has heart disease.

When we found out we could eliminate typhoid fever to such an extent that we could not teach typhoid fever because we had no typhoid fever patients, we began to learn that we could prevent disease. The diagnosis of a disease is a fine thing, but the wiser thing, is the prevention of the disease. That is the ideal to which we are looking forward, and for prevention of disease we need much more expensive personnel than that required for the cut and dried procedures that are associated with the work in the laboratory for the diagnosis of conditions after they have become diseased conditions.

Medicine is a very complicated subject and laboratories do not simplify it a bit. In the first place laboratories require room, and then money for equipment, and experienced people to do the work. Where are we going to get the people to put in the laboratory? Why get technicians; people who carry out procedures they do not understand? A technician is a menace to the institution unless there is someone in the laboratory who can check up. You cannot get that kind of scientist for $15 a week. Until we are willing to pay living wages we are not going to get the best for this important service that is so essential for good work.

Quantity is not what counts in your institution, it is quality, and that quality can be attained only by procuring properly qualified individuals to carry on the work. The laboratory is valuable to the institution only in proportion as the institution is willing to get the proper persons to conduct the laboratory and pay this personnel according to the value it represents to the institution. One thing is certain, and that is, your institution will not progress unless you do take into consideration the science of medicine. We can go a great deal further than we have gone, and your presence here this week is the best evidence of this.

You asked me the importance of laboratories. You cannot keep your staff educated up to the minute without post-mortem examinations. The number of post-mortem examinations represents the interest the physician has given the cases; and the way that the post-mortems are done by the pathologist is again a reflection on the institution. Your post-mortem room cannot be in the cellar next to the ash bin. When there is an unpleasant thing to be done do it under the most pleasant surroundings. No surgical technique is too fine for a post-mortem; do it as finely and as neatly as possible.

Operating Room Equipment for a Hundred Bed Hospital[1]

Alice P. Thatcher, Superintendent, The Christ Hospital, Cincinnati, Ohio

MISS SURBRAY has evidently made a very careful and extended study of this entire subject and given us a complete list of very desirable equipment. However, we are agreed that it is impossible to lay down a hard and fast rule concerning the equipment for an operating suite of a hundred-bed or any-other-number-of-bed hospital without knowing the individual needs of that particular hospital. These needs depend largely upon location, type of work, surgeon's preferences, volume of work to be undertaken, and many other factors.

There is no standard operating room in the truest sense of the word, because the human equation must ever be considered. Each year operating procedures forge into new fields, overcoming old obstacles and bringing about revolutionary ideas on many subjects. With each change in theory there is need for some change in equipment. The result is that certain articles are useful today and obsolete tomorrow. The hospital which renders its fullest service to the public can do so only by keeping up with these radical changes. Therefore it would seem the part of wisdom to have the initial equipment consist only of those items which experience shows are definitely needed at the time of installation, and allow subsequent purchases to take care of new conditions as they arise, either through natural demands, or in accord with the wishes of the operating group.

There always has been and possibly always will be a great difference of opinion in regard to the arrangement of operating room equipment, but there can be no question concerning the importance of carefully planning details. While every possible mechanical appliance necessary in the reconstruction and repair of the human body should be provided, and so placed that it will function effectively and efficiently, it is nevertheless true that the mistake is sometimes made of overdeveloping the operating space with the result that some of it is of very little use. The arrangement of service

[1]Read before the American Hospital Association at Atlantic City, N. J., Sept. 27—Oct. 1, 1926. Released and publication authorized by the Association.

rooms adjacent to the operating rooms is most important. Should these be inaccessible, inadequate or inconvenient, efficiency will be greatly impaired.

The General Sterilizing Room

This should not only be contiguous to the operating room, but in close proximity to the supply or work room as well. Some favor the large size sterilizers, sufficiently large to sterilize a whole day's supply at one time, and the sterilizers attended by a mechanic who thoroughly understands the mechanism of the valves and attachments. This not only preserves the life of the sterilizer, because of expert handling, but saves the time of the nurse as well. The selection of sterilizing equipment should be largely on the basis of utility and maintenance, since modern methods of sterilizing are more or less satisfactory in the standards adopted.

Supply or Work Room

The arrangement of equipment for the supply or work room depends somewhat upon the amount of supplies to be made therein. If all the surgical supplies used throughout the hospital must be prepared in this room, then the equipment should be adequate to meet the demands, and so placed that the maximum amount of work can be accomplished through a minimum expenditure of strength. Indeed this holds true under any circumstances, but especially so if the various departments must secure their dressing supplies from this central point.

Dressing and Rest Rooms

Surgeons' dressing room and rest room adjoining, with the complete equipment suggested, is an ideal situation and one which should be sought by every hospital, but it is reached in its entirety, we fear, by few because of lack of space and funds. If two rooms are not available, perhaps a combination of dressing and rest room could be arranged in one, but a well-equipped dressing room with a sufficient number of lockers, is most essential.

Surgeons' Scrub Room

Some have suggested that the sinks or lavatories in the surgeons' scrub room should be placed high enough so it would not be necessary to bend the back while scrubbing up, and be deep enough and with a front edge high enough to prevent the surgeons from becoming spattered while scrubbing up.

Nurses' Room

Supervising nurses' office, record room, and nurses' scrub room, with their necessary equipment, is indeed an ideal plan and should be arranged wherever possible. From a nurse's viewpoint it is indeed putting "first things first," and this is as it should be, for the demands made upon time, energy, strength, and ability are often almost beyond the physical endurance of its personnel. To conserve these forces will be the only means of attaining the maximum results.

Instrument Room

To have such a room with built-in cabinets, is a great saving of space and of no end of trouble. At the same time it provides opportunity for systematic grouping of instruments in dust-proof cases, as well as affording a place for the instruments belonging to the different surgeons. The cabinet doors should be of glass so the instruments can be seen without opening the doors.

Laboratory

If a fully equipped laboratory cannot be arranged on the same floor with the operating suite, it is most desirable, if not absolutely essential, to have a small room arranged for the examination of gross and frozen specimens.

Anaesthetic Room and Equipment

This room is not necessarily required but some consider it a decided convenience to have such a room for the anaesthetizing of the patients, away from the sight of the operating room with its gowned doctors and nurses, its array of instruments and the hurried movements preceding an operation. Others feel the modern operating room is so attractive and interesting that a view of the surgeons' workshop will be a source of satisfaction to the patient. When the anaesthetic is administered in the operating room the preparation of the operating field may go on at the same time, which saves from twenty to thirty minutes on each operation.

Emergency or Accident Room

No matter how small the hospital, such a room should be provided and as thoroughly equipped as means will permit, since every community has its full share of accidents and emergency cases in these days of high power machinery, reckless driving, unlawful holdups and nefarious bootlegging, but, as Miss Surbray suggests, too much stress cannot be laid upon the importance of the location of this room. When it is so far removed as to be inaccessible from either or both the ambulance entrance and x-ray department, not only is much valuable time lost and indifferent service rendered, but the welfare and best interests of the patient are jeopardized to that extent. Many hospitals find themselves greatly handicapped because too little thought was given to the distance which must be traveled in caring for emergency work.

Plaster Room and Splint Room

A combination of these rooms would be very satisfactory by having built-in cupboards in the plaster room as containers for the various splints, especially if space is limited. If not, then a separate room for splints, large enough and so arranged as to care for all the extra and seldom used equipment of the orthopedic department, would be most desirable.

Dental Room

The equipment for a dental room was not mentioned in the list given but there seems to be a growing need for such a department in connection with the operating suite. The equipment need not be elaborate: (1) Dental chair (hydraulic); (2) cabinet (built-in if possible); (3) gas machine; (4) large unit with cuspidor, light, and electrical and air instruments, atomizers and radioscope work bench for certain laboratory work.

Educational Opportunities of Hospital Standardization[1]

Edward A. Fitzpatrick, Dean, Graduate School, Marquette University, Milwaukee, Wis.

STANDARDIZATION is in these days a word to conjure with. It is one of many words which have gained considerable currency and have served often as a substitute for thinking. The soporific effect of these words is notorious. They gently lull to sleep all capacity for thinking. They are what President Roosevelt called "weasel words." But before the nature of these words is discovered, they are inscribed on the banners of large, even nationally organized, groups and serve as a convenient means for further organization, which is merely mob-ilization, not mobilization. The word standardization itself expresses this whole process that has been going on in business, in education, in every social activity. A group of people of sufficient prestige or power get together, decide the way things ought to be, and immediately declare a new educational standard, or medical standard, or hospital standard, or business standard. They are the great systematizers of business, charity, education. They create these permanent moulds in which all the special activities of life are supposed to run. To an amazing degree they have been successful, and schools of all sorts, libraries, hospitals, have been standardized and classified. Business and industry have seen the same effort with the same results through the efficiency experts.

Hospital Standards Educational

It is to the everlasting credit of the American College of Surgeons that it has devised a form of standardization that does not merely classify an organization, but stimulates it to greater activity; does not confine its energies, but frees them; does not create mere self-satisfaction, but opens up an ever-increasing achievement with the genuine satisfaction that goes with that, and always keeps before the institution an ideal of a still larger service. It is the only standardization for a social institution that is in itself progressively educational. The standard is simply stated, is workable under the conditions in different types of hospitals and according to the development of different sections of the country, and provides an ideal that is capable of progressive development under the influence of larger and larger achievement. The standardizing individual or committee has not abdicated its reason and intelligence on the basis of certain facts without a general consideration of all the factors entering into the situation. Where standards are expressed in exact terms as most standards are, deviations on one or more items are, too often, controlling or decisive, and the morale or service of the institutions, and the attitude, ideal, and capacity of the personnel is not taken into account.

Standards not Merely Statistical

There is another factor. The American College of Surgeons was apparently not afraid of responsibility. The administration of the standard was to be a matter of judgment, not of statistics; and the college was willing to exercise the judgment. In one of the standards, established for colleges and universities, a class of more than twenty-five students is said to impair the educational efficiency. This is maintained in the face of an increasing amount of data to indicate that as education is at present organized the size of class is not a determining factor. And serious men sit in their dignity and with their authority and classify educational institutions on such a basis. The standards of the American College of Surgeons cannot lead to such a situation. The standards of the educational standardizing agency are likely to be stultifying; the standards of the American College of Surgeons are in a very real sense educational. Let us see in what ways and for what group this is so.

Origin of Minimum Standard

In its origin the standard was not primarily or designedly educational, though the form it took, by what might be called almost a stroke of genius, was implicitly educational. The story is undoubtedly familiar to you. The young and vigorous College of Surgeons set up in lieu of an examination a report of fifty major and fifty minor operations. The reports came in on all sizes of papers in all conceivable forms. The need was clear for a set of standardized records. So the hospital standardization began. And early during the war it became necessary to set up a standard for military hospitals and a minimum standard was set up. A year later the American College of Surgeons formulated its minimum standard for hospitals in general.

The Meaning of "Minimum"

There is considerable difference of opinion as to the exact significance of the word minimum. This applies not so much to the standard of achievement as to the essential elements in a hospital service. Said Dr. Martin in 1921:

"Is there anything that a hospital can leave out of that standard and be a hospital? First, records; second, staffs, with staff meetings; third, a competent and honest staff; fourth, laboratories. That is practically the minimum standard of the American College of Surgeons. Any hospital that cannot furnish this minimum standard is not a hospital. It is the very minimum thing we could ask of hospitals to do in order to have us recognize them as hospitals" (1922).

The only thing, it would seem, about the standard that is minimum is the number of items. The factors in hospital efficiency which are essential for the patient's welfare and as an environment for the surgeon's work, are three, (1) an organized, competent, ethical, and professional staff, (2) accurate and complete records, (3) adequate diagnostic and therapeutic facilities under competent supervision. Minimum does not apply to the achievement, nor service, nor efficiency in care of the sick.

[1]Address delivered at the Conference of the American College of Surgeons held at Montreal, Canada, Oct. 25, 1926.

It is, in other words, not a minimum standard in achievement or service or efficiency; in all these things it encourages and expects a maximum achievement at the time with the existing staff, records, and facilities.

The Development of the Minimum Standard

The minimum standard as formulated in 1918 remains essentially the minimum standard of today, except for the change in the fifth standard regarding the supervision of diagnostic and therapeutic facilities. But you must not think that there has been no progress. The standard was originally applied in 1918 to general hospitals of one hundred beds or more and in that first survey, which included 692 hospitals, only 12.9 per cent were approved. In the report made a little while ago by the director, Franklin Martin, 1,055 hospitals were surveyed and 92 per cent were approved. In 1922 the first survey was made of hospitals of fifty to one hundred beds, and in this first survey 41.3 per cent of the 812 hospitals were approved. This is an indication of the educational influence of the standard outside of the group of hospitals to whom it was first applied, and the report made today shows 573 of the 991 hospitals were approved in this class, or 57.8 per cent. Two years ago the first survey was made of the smaller hospitals of the country from thirty-five to fifty beds, and in this first survey 15.9 per cent of the 307 hospitals surveyed met the standard. There has been steady progress since, so that today's report included 18.7 per cent of the 358 hospitals surveyed. Considering the location, facilities, and resources of this small group of hospitals, that is really an excellent showing, and again it shows the spread of influence from the standardization of the larger hospitals.

Conditional Approval—An Educational Device

A stimulus to progress has been the practice of starring hospitals, considerable in number, which have accepted the requirements, but for valid reasons have not carried them out in all details. Recognition was granted the hospital with the understanding that the deficiencies would be remedied promptly. Of course, this meeting of the hospital half-way was an effective educational instrument for it set very intensely practical goals for immediate achievement, as revealed by questionnaire and survey, for trustees, sperintendents, staff, and nurses. And then having achieved the immediate goals, there was need for maintaining the standard and even of developing, for there can be no standing still.

Anticipating Next Steps by Questons on Questionnaire

The basic information was contained in a questionnaire. It makes all the difference in the world what questions are asked. Even before the College is ready to include items in the final judgment of a hospital, questions are asked, e. g., on physiotherapy, which call the attention to this new therapeutic means, which indicate a possible development of hospital equipment or service (and incidentally prevents the growth of quacks) and to reveal how general the use of such new aids have become. Such questions operate as a direct stimulus or challenge to the hospital administrator, the trustees, and the staff, and are directly educational in that sense. The College, as soon as it desires to draw attention to a new factor in hospital administration, organization, or service, may add a new question to its questionnaire. Suggestion has powerful therapeutic effects in hospital and staff.

The Survey an Educational Means

A still further means of educating hospital personnel, particularly the superintendent and the trustees, is the actual survey on the ground. First a competent person on the ground with medical training, and a special training on hospital survey at the office of the College furnishes an intelligent instrument of fact-finding. This contact should be distinctly educational for the superintendent. The presence of such a person at the time the final judgment is made makes possible a more carefully considered and considerate judgment than is practicable with a statistical report alone.

Basis for a Scientific Study of Hospital Administration

The process of standardizing is thus seen to be a process of education particularly for the hospital administrator. In thus providing a means of at least initiating the hospital superintendent into the conditions of effective medical and surgical service in the hospital, the American College of Surgeons is rendering a service to the American and Canadian hospitals of great significance. There is need for a scientific basis for hospital administration. There is pressing need for an organized literature of hospital administration that can be utilized in broadening the experience, or interpreting it, and leading on to further study of both the literature and the practice. The process of standardization as conducted by the American College of Surgeons is developing this literature and furnishing this motive for development.

Educational Opportunities of the Standards Themselves

Now let us see the educational possibilities of the standards themselves. The standards cover three points: 1. Staff; 2. Records; 3. Laboratories.

The fundamental thing in the development of the program itself was records, and this is fundamental in the educational possiblilities of standardization. The current and accurate record of what is done for the patient and what happened, and of examinations, preliminary and final diagnosis, and laboratory findings, furnishes the necessary basis for a scientific study of medicine and the healing art. The current and accurate recording of data is, in itself, a highly educational process. It is not beneath the dignity of any physician or surgeon. It is not incidental or subordinate. The physician or surgeon should view the supervision of this record-making so far as cooperating personnel is concerned as a major responsibility, as it is indeed for staff committee and for staff. When there is no such supervision and study, then record-making becomes merely making records—a time-consuming futile gathering of statistics.

The achievements of the standardization program are genuinely a matter of congratulation, but when the

Public Health Committee of the New York Academy of Medicine reports in its survey of hospital conditions in New York such an array of deficiencies as I shall, in a moment, list, the educational opportunities stand in this fundamental particular revealed. Some of the deficiencies are:

1. No history of patient recorded.
2. Notes are too brief or fragmentary or illegible.
3. Incomplete record or no record of physical examination on admission.
4. Records too brief, uninformative.
5. No record of examination of parts of body affected as given in final diagnosis.
6. No record of physical examination on day preceding an operation—and patient dies from broncho-pneumonia.
7. Provisional diagnosis is not supported by physical findings or recorded history.
8. Provisional diagnosis fails to take account of facts of history or physical examination.
9. Provisional diagnosis differs from final diagnosis, and that from death certificate.
10. Final diagnosis does not include all the conditions which, according to record, seem to be present.
11. Final diagnosis is not apparently supported by the record.
12. Lack of test essential for final diagnosis, for example, Wassermann in a syphilis diagnosis.
13. Autopsy diagnosis reveals condition not contained in the record—or in the final diagnosis.
14. Progress notes recorded at infrequent intervals—apparently accidental or whimsical.
15. No progress notes on day of discharge or on day of death.
16. Members of staff do not record findings on examination.
17. Absence, meagre, or no records of laboratory analysis, counts or tests, where these seem vital.
18. Apparent absence of doctor's orders and relation of patient's condition to medication.
19. Absence of record of consultation or findings of consultation.

Staff Organization

But the most significant of the three items is the problem of staff organization. While the quality set up for membership, full graduates in medicine and legally licensed, competent in their respective fields, worthy in character and matters of professional ethics, are necessary and important, the major contribution in this standard is the fact of organization, and what goes with it, the requirement of monthly staff meetings, policies governing the professional work of the hospital, most important of all "that the staff review and analyze at regular intervals their clinical experience in the various departments of the hospital, such as medicine, surgery, obstetrics, and other specialties; the clinical records of patients, free and pay, to be the basis for such review and analyses."

The significance of organization here is simply this, that we shall profit by our experience, that we shall learn something from what we do and what happens to us. But too often questions of expediency and what is called good-will, but which is faithlessness to the profession, stand in the way of achieving the results that are easily possible under a professional conception of his duty by the staff member.

Organization Prevents Waste

The justification for organization is that it prevents waste, for practically all waste is the result of lack of organization. And in this particular case the issue at stake is the life and death of human beings, and the possible service for the lives of other human beings, in failing to utilize experience, both the successes and failures.

Staff Meeting—A Test of Scientific Training

The staff meeting is the test of the scientific training of the surgeons and physicians. The value of the staff meeting will, so far as its educational opportunities are concerned, be in direct relation to the capacity or the willingness of the members of the staff to assume an objective, impersonal attitude in their discussion of the cases. And the almost proverbial antipathy of physician and surgeons to records or record-making, is evidence of their lack of realization of the educational opportunities of the staff organization and apparently a lack of comprehension of the necessary scientific basis for the development of medicine, and the possibilities of direct aid to themselves in the requirement to formulate exactly the results of their observation and experience.

Staff Meeting—An Agency of Post-Graduate Training

The staff meeting must justify itself as an agency for the continuing of the training of the staff members. It must become, in fact, a seminar. There must be a genuine study of case records (supplemented by autopsies where that is feasible) and not a reminiscent, story-telling smoker, or a mere review of the merely interesting cases, or a perfunctory passing away of time just to conform to the requirement of a monthly staff meeting. The staff meeting, I repeat, must be conducted as a seminar where there is the honest question, and the honest criticisms, and the give and take of frank discussion. I ask you in your conscience to answer the following questions:

Have you frankly stated what you thought where a doctor kept a patient on the table an unconscionable period of time?

Have you indicated to a fellow surgeon whose technique was obviously faulty, just that point in technique which would help him?

Have you ever seriously raised a question where records of two doctors (specialists presumably in the same type of case) vary from 95 per cent operations in one case to 5 per cent in the other?

Have you noticed the failures of a surgeon in certain kinds of cases regularly, and raised no question about it?

These and other questions are a test of your scientific probity, your sense of social responsibility, your conception of your professional obligations. The educational opportunities are wrapped up in your attitude. Or perhaps I can put a question to you in summary form. Is your attitude toward the cases considered in staff meeting, the same objective, unflinching, unmistakable attitude that you have when in the white gown you stand before a human body afflicted with some human weakness or ill, and you do your utmost for

the patient's welfare? Should not your every act in operating room or in staff meeting be characterized by the same attitude, the same purpose, and help achieve the same result?

Laboratories—A Supplementary Agency

The findings of laboratories furnish data to aid in diagnosis, and may help to check the results of treatment. If the attitude of the physician or surgeon is a critical study of his work at all times, the laboratory offers a continuing educational opportunity, but laboratory findings are not a substitute for intelligence or knowledge. They are not automatic. They cannot be a substitute for the careful study of the patient, they should make more accurate that study. They cannot be a substitute for the physician or surgeon. They are merely his aids. And the great problem of physician and surgeon is to interpret them in the light of all the facts regarding the patient. As thus understood, the laboratory becomes an educational opportunity in the education of students in medicine, the continued training of practicing physician and surgeons, and an aid in the development in the science of medicine.

Larger Educational Opportunities Ahead

In conclusion may I say that your hospital standardization program has been a great contribution to surgery, to hospital organization, to scientific medicine. This is so because it is essentially an educational idea. The rendering of your professional services under the conditions laid down is of necessity formative and educational. In thus evolving such a standard, the American College of Surgeons has made a great contribution to education, and its influence is bound to extend into areas of human betterment little dreamed of when it was formulated. But your continued cooperation is essential, and your holding yourself up to the standards every day is the condition of realization. I congratulate you on so great an achievement and trust it may always be administered as intelligently and wisely as it is now, for there is always the possibility of its losing its educational character.

Economical Practices in Hospital Planning[1]

H. P. Van Arsdall, of Samuel Hannaford and Sons, Architects, Cincinnati, Ohio

ARCHITECTS as a rule are not platform speakers and I am no exception to the rule. I therefore beg that you excuse the absence of forensic ability in this modest effort to suggest the way to economical hospital planning and construction.

By economy I mean not necessarily the least possible first cost in building, but rather the minimum cost of suitably discharging the hospital function in maintenance and service. Within the last few years the cost of building construction has advanced much more rapidly than the cost of living (the natural gauge of hospital charges) and consequently it is only through the most careful and painstaking planning that hospitals can be constructed within reasonable limits of cost. The architect seldom has unlimited means at his command for, generally speaking, the building program is much more ambitious than the funds available warrant and for that reason the architect must plan carefully, must have a full knowledge of hospital administration and medical technique, and must utilize to the utmost every available cubic foot of space.

Cost Per Cubic Foot or Per Bed

The average hospital in the middle west is costing between 68 cents and 75 cents per cubic foot complete with all necessary built-in and attached equipment, not including, however, furnishings and movable equipment. This price is based on well planned and economically designed buildings. Building committees are often told that hospitals will cost so much per cubic foot or so much per patient bed. Both of these figures are misleading unless you consider them together. An architect may design a building with all rooms oversized, which would result in a low cubic foot price and a small bed capacity. On the other hand, with all rooms undersized, your cost per cubic foot would be excessively high but bed capacity large.

Because economical consideration in hospital operation may not be overlooked, the building must be designed to fit the service like a comfortable shoe. The various departments must not only be so correlated as to eliminate unnecessary traffic and excess help, but they must be neither too large nor too small. Either fault means increased operating cost through increased personnel or in vexatious hindrances to essential service. In arriving at a fair estimated cost per cubic foot, your calculations should therefore be based on well proportioned room sizes, giving a maximum bed capacity with easy accommodation of the various services.

Many Ceilings Too High

Few building committees realize that for every extra cubic foot of space added to the size of a room an additional 68 cents has to be raised, and it is at this point that one of the principal economies in hospital planning can be exercised. In visits to various hospitals old and new throughout the United States, I have found many private patient rooms 12 feet wide by 17 feet long, with ceilings ranging in height from 10 to 12 feet. A room of this size, 12x17x10 feet, contains 2,040 cubic feet. This is far in excess of present day requirements. Most of our state laws require a minimum cubic foot allotment of approximately 1,000 cubic feet for private patient's room, and good practice demands between 1,400 and 1,500 cubic feet. I believe it is agreed by many hospital consultants and architects that a room 10′ 2″ wide x 15′ 6″ long is ample in area for the best private room. However, the question of ceiling height is little discussed and it is this that I want to call to your special attention. Assume that your

[1]Read before the American Hospital Association at Atlantic City, N. J., Sept. 27—Oct. 1, 1926. Released and publication authorized by the Association.

floor area, 10′ 2″ x 15′ 6″ is correct. To arrive at a cubage of 1,450 feet your ceiling should be approximately 9′ 2″ high. Suppose, however, the architect made a ceiling 10′ 0″ high instead of 9′ 2″; there would be a clear loss of 132 cubic feet, or approximately $89.76 per room. But do not lose sight of the fact that when you raise a ceiling in one room this same height must extend throughout the floor. Imagine having a hospital 45′ 0″ wide x 200′ 0″ long, which is an area of 9,000 square feet; now increase the height of your ceiling one foot. Do you know that you have added 9,000 cubic feet, or an additional cost of approximately $6,120, and at the same time added forever an increased up-keep cost for cleaning, painting, and heating? Now, suppose you have six floors of bed rooms, you have increased your building costs approximately $36,720. You no doubt will say that your architect should know better—he should, but by visiting some of the new hospitals in the nearby vicinity you will find that this statement is true. The matter of ceiling heights is a very important one and should never be neglected in the study of planning problems.

I can cite other instances. Take the kitchens in many of our institutions and you will find ceilings ranging in height from 12 to 16 feet. No doubt the reason for this is the exposing of steam and plumbing pipes, and heat and vent ducts. When a kitchen is properly planned and equipped, heat and vent ducts and pipes of all sorts should be eliminated entirely from the ceiling, not only to save the excessive ceiling height, but for the purpose of cleanliness and neat appearance. Pipes carrying steam, gas, and water may be run in furred spaces on the ceiling below, while the vent ducts from ranges can be drawn down underneath the floor and discharged vertically through a shaft to the roof. With the absence of pipes from the kitchen ceiling the height may be cut down to a minimum of 11 feet.

Concealed Piping

I must digress for the moment to defend the statement just made regarding the concealment or running of pipes in furred spaces which is a radical departure from usual practice. Some twenty odd years ago our leading hospital consultants and architects invariably exposed all steam piping throughout their buildings and would not permit them to be installed in any other way. Mechanical practice has proved beyond a doubt that when low pressure piping is properly installed and of the right materials it can be concealed with only a remote possibility of leaks. In the use of concealed piping some precautions should be taken, and as a safeguard it is advisable to install at convenient points in the furrings small flush metal access panels or inspection doors, which give an easy means of detecting leaks and the making of quick repairs. We find concealed piping installed in practically every other type of large building, and I can see no good reason why we should continue an obsolete practice in hospital construction that is an eyesore, unsanitary, and expensive.

Regarding waste of cubic contents, we find the same condition existing in major operating rooms, many of which are 18 feet wide by 24 feet deep, with ceilings 11 to 16 feet in height. Why these excessive sizes I do not know, since for all practical purposes a major operating room 16x20 feet with an 11-foot ceiling is sufficient. These rooms as you know are today equipped with mechanical ventilation, and lighting units which are heatless, so there can be no good reason for such extravagance. For years major operating rooms have been equipped with large and expensive skylights and steel sash. These are not only expensive in the original construction cost, but are a constant source of expense for upkeep. The majority of present-day surgeons are constantly operating under artificial light, and if you are willing, the cost of the skylight construction can be easily omitted with a consequent large saving.

Plan Building to Fit Equipment

In the planning of room arrangement and the spotting of the various units in any hospital structure, you should insist that the architect, at the time of making sketches for the building, lay out every piece of furniture in the different units so that all waste space can be saved. This portion of the work requires the most careful study and should be thoroughly worked out in the sketch stage. On the other hand a more serious loss can be had if the units are planned too small, since this will hamper your entire plan of management and operation. Seldom will you go wrong if you make your architect plan the equipment locations at the time of planning the building. If your architect is unable to do this then he is unfit to undertake your problem.

The planning of a hospital is not a simple matter. Indeed it is considered by the architectural profession the most highly technical problem that an architect has to solve. I have attempted to explain in a practical way how architects and building committees can, in all good faith and with the best of intentions, unknowingly spend many thousands of dollars that might, by careful planning, have been saved.

Selection of Materials

We now come to another interesting problem, and that is the selection of materials. I propose to discuss only those materials that enter into the construction of a fireproof building, as any other type of construction should be prohibited by law. The average architect or building committee seldom errs in the selection of brick, stone, or terra cotta, but by judicious care in the choice of some of these and other materials many savings may be made.

Where the concrete skeleton type of building is employed, you will understand that the exterior walls are usually constructed 13″ thick, that is, the first 4″ of thickness consists of an impervious face brick; the other 9″ being of hard burned common brick. Good practice teaches us that the 9″ thickness may be constructed of a hollow tile back-up block since the wall is for enclosing purposes and supports only its own weight from floor to floor. At the same time the hollow tile will act as an

insulator against heat and cold. On some of our recent work we have made a saving of one-half of one per cent on the entire cost of the building by the use of this material.

The practice of using sloped tops on cases, refrigerators, lockers, etc., is undesirable, in my opinion, as it is cheaper and more sanitary to furr in their heads. We often find doors to the patients' bedrooms equipped with three tumbler locks, door knobs, escutcheons, and checks. These are expensive and noisy in operation. The use of an arm hook on the room side of the door, together with a friction thumb latch will not only be less expensive, but will do away with noise. In addition to the arm hook the door should be provided with a door check, a flush pull on the corridor side and a lock that may be used when the room is unoccupied. On all closet doors use only one knob and that on the room side.

Blanket, solution, and bed pan warming closets should be of the built-in type and made a part of the original construction work.

One of the largest items of expense in any hospital is wall tile. We find it used as wainscoting in kitchens, utility rooms, serving pantries, treatment rooms, operating, sterilizer, and scrub-up rooms, and in all toilets and baths. For the sake of economy, tile wainscots in kitchens, utility, treatment, bath, and toilet rooms need not be run higher than five feet. In operating rooms it is probably better to extend it to a height of seven feet. The greatest economy, however, that can be made is in the selection of the material itself. There are three grades of tile—"Select," "Standard," and "Commercial." The "Select" grade costs approximately $1.90 per square foot, the "Standard" $1.80, and the "Commercial" $1.50. "Select" tiles are without flaws and should be used only in operating rooms. The next grade, "Standard," permits of small inaccuracies in manufacture, but of such a nature as the layman would not detect. These may be used in sterilizer, treatment, toilet, and baths throughout, while the third grade, "Commercial," is easily acceptable for kitchens and utility rooms. It is not unusual to find that your architect has specified all tile to be of the "Select" grade which is, of course, an extravagance, as a large saving can be made when the cheaper tiles are used.

Piping to Suit Requirements

This same practice can be employed in every branch of the work, for instance: All hot water lines throughout your building should be of brass (iron pipe size), as this material will last a lifetime and will free you from piping repairs. We often find that in order to go ahead with a project hospital authorities are willing to use galvanized wrought iron pipe instead of the brass in order to save on the first cost. It has been my experience that on hot water lines wrought iron pipe will last about six years, then leaks develop and you are put to a large expense not only for plumbing repairs, but the expense of ripping out floors, partitions, etc. The additional cost for brass is slight and wherever possible it should be used. On cold water lines you will be perfectly safe in using the galvanized wrought iron pipe.

Fire lines or stand pipes may be made of steel, as the water in these remains stationary except in case of fire. Pipes carrying high pressure live steam may be made of extra heavy steel, but always use genuine wrought iron where pipes carry condensed steam. The use of the steel pipe will effect a saving of approximately 25 per cent on the cost of the material. In connection with the plumbing fixtures there is a waste pipe which runs to the basement sewer and a vent which extends to the roof. In buildings of two stories and over, the waste and vent pipes are usually made of genuine galvanized wrought iron. This is necessary in the case of the waste pipe, but the vent line may be made of galvanized steel instead of iron. Saving on this one item amounts to about seven per cent on the average hospital plumbing job.

Where acids are used in such rooms as the laboratory and pharmacy, all waste lines should be made of acid resisting pipe, else you will come to early grief. Recent reports of the Research Committee of the American Society of Sanitary Engineers recommend the use of acid resisting pipe on kitchen wastes. In the purchase and selection of electric and plumbing fixtures, use only those best suited for the purpose intended, then buy the best quality. Plumbing fixtures are constantly in use and unless built for hard service you will experience much trouble.

In the purchase of finishing hardware such as latches, knobs, escutcheons, push plates, and hinges, a slight saving can be effected in the kind of material used. Nearly all hospitals are equipped with cast bronze or brass material, whereas a substantial reduction can be made in the cost if you use cast brass or bronze for all exterior openings and for the interior doors, cast iron or steel finished in "Bower Barff," which will be just as serviceable and as good to look at.

Efficiency Vs. First Cost

I shall not go into the matter of boilers, laundry, and sterilizing equipment. The field is well occupied by numerous dealers and manufacturers of specialties, the merits of which depend very largely at least on the user's point of view and on his familiarity with the apparatus. Suffice it to say that first cost should not be the first consideration. The machine which does its work at the least expense per unit of output is the more economical regardless of price. The higher cost is soon absorbed by cheaper operation.

The time allotted for the reading of this paper is too short for a lengthy discussion of the proper planning of facilities to meet only operating needs.

Luxuries Not Necessities

If building costs are to be held to a minimum we must omit from our building programs such things as utility facilities connecting with each private room;

private baths for a large portion of the private patients' rooms; special metal cabinets and cupboards in private rooms, and so on. These facilities are luxuries, and of course are desirable, but we must not educate our people to believe that every hospital constructed, must of necessity have them. It seems to me that we should strongly discourage the inclusion of such specialties, unless the hospital is the possessor of unlimited means. The time has come when those having building operations in charge should give ample time to the study of hospital planning and aid their architect in every way possible towards a proper solution of the problem.

Friendly Cooperation Necessary

In conclusion, let me say that an architect is primarily a master builder and that his principal function is building. The information which he brings to the solution of the hospital problem is necessarily acquired by contact with superintendents, supervisors, physicians and surgeons, and others, and from observation in many similar institutions, and is therefore a composite of many minds.

He may well be counted as authority in such matters. Nevertheless, each project is a separate problem; local practice, preponderance of one class of service over others, personal bias of operating bodies or persons, are all to be taken into consideration and successful developments are to be achieved only by the friendly cooperation of all those most nearly concerned. There is an old adage which says, "There is wisdom in a multitude of counselors," but the other aphorism should not be forgotten, namely, "Too many cooks spoil the broth."

Greetings From the Hospitals

Christmas! Word of magic—season of peace. The Infant King reigns, His throne a manger. With His tiny hands He showers His gifts upon the world.

'Tis a time for remembering God's poor, for thought of others, for gladdening the hearts of our friends with the oft repeated greeting.

This greeting we send to you, dear Father Moulinier, and to your co-workers. May all the joy of Christmas be yours. May the Christ Child bless your work, and make all your plans for hospital improvement, materialize. May HOSPITAL PROGRESS continue to inspire and encourage its readers, and become a necessity to all who are engaged in the care of the sick.

Sister M. Alphonsine,
St. Mary's Mercy Hospital, Gary, Ind.

To the Editor and Staff Members of HOSPITAL PROGRESS, we extend our most cordial Christmas Greetings, and express our appreciation of their splendid magazine, with a wish that this valuable periodical may find a still wider circulation in the coming New Year.

Sisters of Charity of the Incarnate Word,
Galveston, Texas.

Glory to God in the highest and Peace on earth to men of good will!

May Bethlehem's blessings, peace, content, humble and holy happiness fill the hearts of all whose life work is devoted to alleviating the suffering of the brothers and sisters of Jesus Christ.

May that divine charity brought into this world by the Infant King, radiate into our hearts and produce abundant fruit in our service to humanity.

Cordially,

Mother Andet,
President of the Maritime Section of the C.H.A.

Festive bells are again proudly proclaiming the New Year. May they joyously resound in the hearts of all readers of HOSPITAL PROGRESS. May they peal forth a double refrain to our greatly esteemed Rev. C. B. Moulinier and his co-workers in gratitude for their wholesouled devotion and untiring zeal in this noble cause. May a Happy and Prosperous New Year crown with continued success their earnest efforts in the various phases of hospital activities.

Mother M. Bernarda, O.S.F., Superior Provincial,
St. Elizabeth Hospital, La Fayette, Indiana.

The Sisters and staff of Mercy Hospital, Iowa City, extend to our dear Father Moulinier, The Catholic Hospital Association, HOSPITAL PROGRESS, and all its readers, our sincere wishes for a peaceful and happy Christmas and may the Holy Infant Jesus send you every blessing on the New Year.

Mercy Hospital, Iowa City, Iowa.

Congratulations once more to Father Moulinier! Congratulations to HOSPITAL PROGRESS! Congratulations and best wishes to all the members of our Association. Every year seems to draw us closer together in mutual appreciation and a mutually helpful spirit. Let us renew our youth with the year and keep wide awake for another twelve months.

St. Vincent's activities this year have been directed toward increasing the value of our staff meetings. Our annual report will contain the details. Our only actual plan for the New Year is to develop a patients' library which in a very modest but definite way has been initiated.

Since we are still cataloguing the books we have now on hand we are not prepared to make any additions at present but of course, many of Father Garesché's books have reserved seats on our shelves.

With very best wishes, I am, sincerely,

Sister Michaella, Superior,
St. Vincent's Infirmary, Little Rock, Ark.

Greetings from St. Mary's Hospital, Cairo, Ill., to the editorial staff of HOSPITAL PROGRESS; also to the many readers throughout the land. May your great magazine grow in size and progress during the year 1927.

St. Mary's Hospital, Cairo, Ill.

At this holy Christmas season the Sisters of St. Francis, St. Anthony's Hospital, Denver, Colorado, sincerely wish to extend to Rev. Father Moulinier, his coworkers and to the large family of readers and friends of HOSPITAL PROGRESS their heartfelt greetings.

St. Anthony's Hospital, Denver, Colo.

The Christmas Chimes will soon be pealing forth the old, old story ever new, and to their merry peal I wish to add my little note and bid them carry it far and wide to all those other Christs who are inspired by the monthly messages of HOSPITAL PROGRESS to help suffering humanity back to health and cheer, this holy Christmas season.

May it also bring to you, dear Father, all the blessings of the Christ Child, and length of years to continue your good work.

Yours sincerely in Christ, *Sr. M. Eugenia, O.S.D.,*
Mary Immaculate Hospital, Jamaica, L. I., New York.

A Happy Christmas, a glad and progressive New Year, St. Joseph's Infirmary, Fort Worth, Texas, extends to HOSPITAL PROGRESS, its readers, helpers, friends, and advertisers, its best wishes for a very happy Christmas and many a glad and progressive New Year.

May the happiness that radiates from the Babe of Bethlehem—God's first Christmas gift to the world—enter the hearts and brighten the homes of every helper of the cause sponsored by the Catholic Hospital Association.

A glad New Year to each and all, glad in the consciousness of a great aim in furthering the work, the redemption of humanity by Charity which Christ came on earth to enkindle on Christmas night.

A progressive New Year widening its Catholic territory, gathering its great Christian forces until the unrolled years that are yet to be, bring all under the banner of Christ our King to work and to sing for the glory of God in the Highest.

Sisters of Charity of the Incarnate Word,
St. Joseph's Infirmary, Fort Worth, Texas.

Greetings to our Catholic Hospital Association of the United States and Canada:

The most joyous of all seasons, the season of greetings, Christmas, the birthday of our Savior, Christ the King, is again approaching and it seems but fitting that in our greetings, our dear Association should be uppermost in our mind. Yes, Catholic Hospital Association, scarcely out of your swaddling clothes, you have been the guiding star and the directing hand of our hospital activities! We greet you with glad hearts and through your columns we greet our worthy president, officers, and members, each and every one. May you continue to grow in strength and numbers and may you reap the harvest of a work faithfully done to suffering mankind.

Our greetings we extend likewise to HOSPITAL PROGRESS, which has become a phenomenal success for the betterment of our hospitals, one that is recognized throughout the continent and abroad, as fulfilling a real need among nursing Sisters of the Catholic world.

Before the advent of the Catholic Hospital Association and its Official Organ, HOSPITAL PROGRESS, our hospitals were isolated units, knowing little of the progress and science outside of our own walls. Through our magazine we are kept in touch with other institutions, our interests are in common and this interchange of ideas can but tend to the promotion of modern science and medicine, by which we are all benefited.

Carry on, little messenger, your good tidings of health and cheer to every hospital in the land and as the little mustard seed, may you grow and extend your widespread branches over many more members who would welcome you, could they but know you.

The Sisters of Misericorde,
Misericordia Hospital, New York City.

A Merry Christmas, with best wishes for a Happy New Year, to all who have made HOSPITAL PROGRESS such an inspiring magazine, to which all look forward with eagerness and expectation; and to all the privileged readers of the same.

Sisters of St. Joseph's Hospital, Keokuk, Iowa.

To Rev. C. B. Moulinier, S. J., President of the Hospital Association, Rev. E. F. Garesché, S. J., and co-laborers, the Angels' Greetings!

May the Infant Saviour shower His choicest blessings and bind all with the cords of His divine love, that much good may be accomplished. May the year 1927 for HOSPITAL PROGRESS be a year of special benediction, for it is one of the strongest agencies for promoting and encouraging hospital work.

Father Garesché is to be congratulated and the warmest thanks are his due for his untiring zeal and energy in producing such a magazine and making it a success for the benefit of those who are engaged in hospital work; consequently, cooperation and assistance should gladly be given him by all institutions. In fact, by all who are interested in the care and welfare of Christ's suffering members. Gratitude and thanks should also be extended for the great good done by him in organizing Sodalities for nurses, for those young women are exposed to many dangers and temptations. For the allurements of this modern age are inebriating, hence a Sodality is a safeguard for their spiritual and social life.

Sister Wenceslaus,
Providence Hospital, Oakland, Calif.

We wish to extend to HOSPITAL PROGRESS, its officers and our co-workers in the field of charity and mercy, our sincere well wishes for a Joyous and Happy Christmas, with the earnest hope and prayer that the choicest gifts of our Infant King may be poured out on you and yours as your Christmas portion.

May this Christmas be for you all, the forerunner of many others that are to follow as your inheritance; and then in the end, an everlasting Christmas, with Him, in His Eternal Home.

Roselia Foundling Asylum and Maternity Hospital,
Pittsburgh, Pa.

Christmas brings the opportunity of expressing our appreciation of all that HOSPITAL PROGRESS is accomplishing in the way of education and in the betterment of hospital work.

May the Christ Child continue to spread His spirit on the hospital world through our Association and its official magazine, HOSPITAL PROGRESS.

Sisters of Mercy,
Mercy Hospital, Jackson, Mich.

What shall be my Christmas wish? May the Divine Infant bless all those who are laboring so unselfishly for the betterment of our Catholic Hospitals. Merry Christmas, Father, to you and to all the members of your office staff.

Sincerely yours in J. M. J.

Sr. M. Paula,
City Hospital, Charlottetown, P. E. I.
St. Anne's Hospital, Chicago, Illinois.

Grading Schools of Nursing[1]

Leo W. Hornick, M.D.

IT is a great pleasure as well as an honor to appear before this distinguished body of hospital and nursing school executives. The pleasure it affords me arises from several sources. One is the fact that it gives me an opportunity to say how deeply indebted I feel to our Catholic Sisters. Many of the foundation stones of whatever success I may have attained were placed by Sisters. It is significant to me that the beginnings and endings of my school career were found within the walls of a parochial school and a Catholic Sisters' hospital. A second reason lies in this, that I may express an appreciation of the great work which our devoted Sisters of Mercy have been doing in and for Johnstown. This hospital has been in existence over a brief span of years. It was founded in 1911. Its beginnings were most modest. Its growth was hampered by many difficulties. True, such has been the history of almost every hospital conducted by Sisters, yet that does not detract one whit from the great credit due these Sisters who by their unswerving loyalty to a high ideal and their unceasing efforts and labors have developed Mercy Hospital from its inception to its present proportions (from 12 to 100 beds), who have made of it an institution whose service is one of the vital necessities for the well being of this community.

As for all hospitals of its kind, this service is not limited to one definite objective, but embraces several distinct though intimately correlated lines of activity. The great purpose may be stated briefly—for the honor and glory of God to serve the sick and injured. This is to be accomplished through the medium of the management with their physical hospital and equipment, of the physicians whose workshop and study is the hospital, and of a corps of well trained nurses. Stated differently we may say that the management supplies a place fitted for the scientific care of the sick, a place where physicians can more successfully treat patients and acquire greater skill and knowledge, a place where student nurses can be thoroughly educated by didactic and bedside teaching in the theory and practice of nursing.

The last named function concerns us today more particularly. You are especially interested in the proposed grading of training schools for nurses. When I was asked to speak on this subject from the viewpoint of the physicians I had to confess that it was new to me. I doubt whether I can add anything worth while to the discussion of a subject of which you have a larger and more intimate knowledge. I am somewhat consoled, however, by the impression I received on reading several recent articles on the grading of training schools. The whole proposition seems to be in an early, embryonic stage.

The past ten years have seen tremendous strides in medicine and surgery, preventive medicine, medical education, and hospital service. Grading and standardization have been accomplished with undoubted beneficial effects. Through the investigations of the Carnegie Foundation, medical schools were graded. In a few years, most of the incompetent schools, the shams and frauds and diploma mills closed their doors. Schools of dentistry have adopted a similar method. The American College of Surgeons set up a standard for its fellows. They soon found that it was as necessary to establish a standard for their workshops, the hospitals, as for the workers, the surgeons. We are all cognizant of the benefits to surgery and to hospitals from this movement. Of the hospitals of 100 or more beds visited in 1918 only 13 per cent were rated in class A, while in 1924 over 96 per cent of a larger number met the requirements. The more recently organized College of Physicians has a similar objective.

If the results of standardization of medical colleges and hospitals together with medical and surgical practice are almost universally acclaimed, is it not reasonable to expect similar improvement from the standardization of nursing schools? The department of nursing is now the only member of the family occupied in the care of the sick which has not definitely joined this movement. No one will dispute the fact that the nursing corps is a very important cog in the wheel of efficient service to the sick. Then surely it is equally important that you should seriously entertain a standard for the education of nurses. In my opinion it is necessary to complete and round out the whole scheme. It follows the rest of the movement naturally.

The committee on nursing schools of the Catholic Hospital Association in its study of curriculum, records, training school reports, and textbooks noted, "a marked lack of uniformity in curricula, textbooks, and records in the Catholic nursing schools in this country and Canada." The same criticism no doubt applies to all nursing schools. The time is then ripe for some standardization at least on those fundamental principles which should be the same everywhere.

There are today over 1,800 school for nurses. The increase in the number of schools and the rapid advances in medicine and surgery have added greatly to the complexity of the problems you have to meet. They have made it necessary to get away from the apprenticeship idea whereby a hospital got the student nurse's service cheaply and the nurse incidentally picked up a training, good, bad, or indifferent according to the sense, the ability, and the sense of responsibility of the superintendent. Conditions of today demand an educated nurse, and have created the need for uniform and concerted effort to produce her.

Standards are now much higher than formerly. Still there is need to formulate, from the experience of many teachers of nurses, at least a minimum standard

[1]Read at the fifth annual conference of the Pennsylvania section of the Catholic Hospital Association, April 12, at Mercy Hospital, Johnstown, Pa.

universally acknowledged to embrace those basic principles without which a school cannot be a good training school, be it in New York or San Francisco, in New Orleans or Montreal. Anything that will promote greater efficiency and intelligence in the care of the sick, that will encourage the slipshod school to throw aside its careless methods, that will make for uniformity of practice, where settled principles are concerned, without killing initiative, that will correlate the instruction given with the scientific needs of the day, is to be encouraged.

Such is evidently the purpose of the committee on grading which met and organized in March, 1925. The committee stated the purpose of grading to be as follows: "The progressive improvement of schools of nursing not only as educational institutions but as institutions for the care of the sick and the promotion of health in the community." It is well put—especially the latter half of the sentence. Beyond this the committee does not seem to have gone. It is well to remember that success will attend only an organized effort. An organization with concerted action under capable leadership can better materialize the plans of thinkers than the sporadic activities of individuals or separate groups. So important a work should not be given into the hands of laymen but should be delegated principally to the far sighted leaders of your own profession with perhaps some collaboration from those who have successfully put over the program of hospital and surgical progress.

How far should such standardization go? On this point there seems to be no definite opinion. I agree with those who say that the actual statement of principles should be a short and precise exposition of a minimum standard below which it will not be safe to go. There should not be an arbitrary exclusion of those who do not conform immediately, but such schools should be helped to see the light an encouraged to follow it. Such a standard should concern itself with the scientific equipment of the various departments of the hospital, the diet kitchens and laboratories, the entrance requirements, records, curricula, and living conditions. A standard of requirements for superintendents, instructors and floor supervisors would appear to me very important. The effectiveness of a school depends on the quality of the instruction given and its correlation to the practical bedside work. The quality of nursing while in training and after graduation is largely in ratio to the excellence of such instruction. I believe that superintendents, instructors, and floor supervisors should have special training—they must be executives and teachers as well as nurses. Some of this special training should be secured in other hospitals than the one in which they were student nurses lest their own school eventually suffer the ill effects of too much inbreeding.

While I favor this movement I would urge some caution. Standardization should not be overdone. None of us would like to see the Ford idea applied to hospitals and nurses. There should be a proper ratio between theoretical and practical work. Curricula should be comprehensive but not crowded with unessentials. We do not need pathologists and physiological chemists who cannot count a pulse accurately or intelligently report the patient's changing symptoms to the physician. In considering the nursing school as an institution too much importance is sometimes attached to the classroom and too little recognition given the potentialities of the wards of the hospital for teaching those same theories in their practical application. Do not separate the nursing school too widely from the hospital, for the latter is still and always must be largely the school.

In conclusion I wish to quote the Rev. C. B. Moulinier who, in speaking of the standardization movement of the College of Surgeons in 1922, said: "Some five or six years ago the American College of Surgeons, stirred down to the depths of its soul, began to realize that it had a mission to fulfill for the better care of the sick in the United States and Canada and made up its mind to improve surgery. But everybody knows that you cannot improve surgery unless you improve everything that centers in the work of the hospital and so the American College of Surgeons had not gone very far into its effort and purpose to improve surgery when it realized that it had to improve everything in medicine." And he might have added "in nursing," though I am sure he implied it. He adds: "There is no doubt of it, gentlemen, if I am at all safe in my conclusions in the reading of history that there has never occurred a movement equal to it in the past history of our race."

Let me express the hope that the nursing profession will soon become a part of this great movement, and that Catholic nursing schools will be adequately and enthusiastically represented.

At the time when God's infinite love for men stands out in overwhelming precedence over all His other works, it seems peculiarly fitting to tender to an organization like the Catholic Hospital Association, assurance of prayerful good wishes for its farther growth and for the continued success of its merciful mission.

With kindest Christmas greetings and a blessing, sincerely in our Lord,

✠ *Paul P. Rhode,*
Bishop of Green Bay.

Greetings to HOSPITAL PROGRESS

We have taken tender thoughts—
And wishes quite a few—
And added happy memories,
We shared so oft with you;
And mixed 'em with our blessings—
And sent 'em all away—
To one of our treasured friends
For Greetings Christmas Day.

Mt. St. Mary's Hospital,
Niagara Falls, N. Y.

Hospital Progress

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GREETINGS AND RESOLUTIONS

To the readers of HOSPITAL PROGRESS who live and work in the New Year: May God bless you and keep you well in soul, mind, and body.

Last January we published our New Year's resolution to record your progress for the year faithfully and accurately. While supplying a record of your achievements, we have tried also to find articles suggestive of means for your continued growth and improvement in service to the sick. The criticisms and suggestions from some of our readers have been a help. Some have told us what they would like to have in the magazine. The editors have made note of such requests and are on the lookout for articles on some of the subjects suggested. Perhaps a few of these subjects can be discussed better in book form than in the pages of a magazine. Superiors, Sisters, nurses, and doctors have found in previous issues of HOSPITAL PROGRESS material suited to the special needs of each. It shall be our aim during 1927 as it has been in the past to serve *all* classes of readers in *all* our hospitals, large and small.—*E. W. R.*

SUPERFLUOUS PRINT

"How many thousand square feet of filing cases are wasted, and how many thousands of pounds of paper are used in vain, because of the plague of superfluous print which has fallen upon our hospitals!" The speaker was the head of a large out-patient department in a city hospital, and had had many years' experience in hospital purchasing and organization. He pursued his train of thought somewhat as follows: "If some efficiency expert should come along to investigate the records and filing cases of our hospitals, would he not find a very great waste of materials because of unnecessary printing? The fact that records are made too large, that cards are decorated with useless wording, means not alone a great deal of extra labor in typesetting. It means also that a huge bulk of paper is unnecessarily employed to carry this superfluous print. This again means a great space for filing. As records accumulate, from year to year, the using of needless additional square inches on cards and records will mean the employment of many superfluous square feet of cabinet or storing space.

"Thus, for example, the cards used in card indexes, which are never referred to except by the office staff, are all carefully headed with the name of the hospital and sometimes with the city address. This is quite superfluous, as nobody could possibly make any mistake as to what hospital is intended, and it does no good at all to put the name of the hospital on the card. But the paper thus used mounts up enormously. So too, the office force soon learns to fill in the cards automatically, so that it is useless to print in full the various headings on the form. Instead of 'Name, address' and the other details it would be enough to print the letter, N., A., etc., and this would give all the information required at a great saving of pasteboard."

The executive in question could point to a very small filing case, which contained 100,000 cards of his own designing, with the superfluous print eliminated. It would take at least twice as much filing space to keep 100,000 of the record cards, commonly used in our hospitals. Of course, one must observe the golden mean in such matters, but there is occasion here for real thought and care on the part of hospital executives. Looking ahead twenty years into the future it is easy to predict that if records go on growing in bulk, hospitals will have to have a special building to keep them unless due economies of space and paper are observed.—*E. F. G.*

HOSPITAL PHYSIOLOGISTS

The position of the hospital pathologist is accepted and fixed; a modern hospital needs him and provides for him. Is it chimerical to suggest that we should have hospital physiologists? If this is asking too much, then it is surely not presumption to suggest that pathologists become interested in the biochemical and biophysical points of view that presently promise so much.

Every hospital laboratory should be fully equipped for gross and microscopic tissue work and bacteriology. However, a casual review of our leading current medical journals shows a decided trend toward research, based upon studies that could not be carried on with these agencies alone. In fact, it is possible that medical science has neared its zenith of development along investigations of form and structure alone. It must never be forgotten that the microscope is only an elaboration of vision and the art of inspection. Discoveries—using the term reservedly—have long ceased to dominate the horizon of the anatomist—at least as far as practical anatomy is utilized by physicians. In contrast to what might be called this fixed attitude, witness the brilliant clinical triumph that has come through the recent utilization of well known physiologic laws and principles: the crucial importance of the blood chlorides in maintaining acid base equilibrium in the body fluids; the matter of blood plasma concentration in connection with edema and diuresis. From the former we have the dramatic cure of the terrifying postoperative complication—acute dilatation of the stomach (upper ileal stasis); from the latter, an understanding of the magic working of a newer drug—Novasurol—in certain states where anasarca and serous cavity filling supervenes.

There is nothing in the term "pathology" to indicate that perversions of chemical and physical balance are without its domain. For purposes of classification and instruction, well known to everybody, precedent has split up premedical and medical education into well known segments. Misfortune, however, follows altogether too certainly where medicine, taught segmentally, is supposed to be practised co-ordinately. Young graduates carry over into their professional life the principles of the basic sciences taught them in proportion as their immediate clinical teachers give them the acumen to understand these principles and the basis for incorporating them into their professional life. It is time that those teaching these elemental sciences should come into our clinical conferences in the same understanding manner that pathologists have done. In fact, one begins to see why the first year medical student in Paris University is taken into the wards. Is it not obvious that a student having stood by the bedside of a markedly dyspneic patient is going to have a keener basis for attempting to understand the physiologic perversions back of air hunger, cyanosis, and edema?

Finally, would it not be better for all of us, if, we viewed a variety of dominant symptoms, such as edema, hyperpnea, oliguria, etc., as indications of disturbed physiological balance, rather than chief components and clinical syndromes, designed chiefly to provide us with a diagnosis that is little more than a name? The folly of this is best seen when we find a variety of papers upon closely related subjects, where, without a jury or a court to establish accepted definition of terms, an understanding must be largely read into the paper by those who sense the writer's point of view. An article by an able clinician on the subject of "Air Hunger" comes to mind; another one on "Pulmonary Edema"; still another on "Cardiac Asthma." Each writer splits up his subject even as Caesar did ancient Gaul. We have abstracted the term "fever" from the grab-bag of indefiniteness, and aside from the "P. U. O." of the war time, fever is no longer considered in any other light than a physiological intimation of constitutional disease. Let us hope that we may soon do more with physiology and its allied sciences, in our hospitals.—*E. L. T.*

THE GIST OF THE STAFF MEETING

When a staff meeting is rightly conducted some very interesting information results. The discussions especially are extremely illuminating at times. A good local conditions and is of merely local interest. But every now and again observations are recorded, remarks are made, and conclusions reached which are of permanent value and general interest. These should certainly be recorded and the best of them should be sent to Hospital Progress for publication. How else can our readers share the good things which each hospital can contribute unless some such effort is made to send us the gist of what is best in the hospital?

Of course, it is too much to expect that the secretary of the staff should take down all these things and preserve them in the minutes. This will require the services of a competent stenographer, but such services might be supplied by the hospital. It will be well worth while to preserve these discussions from the viewpoint of the hospital itself.

To extract the gist of these discussions and send them to Hospital Progress might be the task of the president of the staff or the secretary. He might use the blue pencil on the stenographic report, boil it down, cut out whatever is not suited for general publication or is of merely local interest, have the stenographer recopy it and then send it on to us.

If a great many such reports came in, a selection could be made and a very interesting department established which would be of general value. We hope the presidents of our staffs will take this suggestion seriously to heart.—*E. F. G.*

THE SMALL HOSPITAL

Again and again we have been told by Superiors of small hospitals that they have not sent news, etc., because they feel that, inasmuch as we are in contact with so many larger hospitals, we cannot be greatly interested in the doings of the smaller institutions. Let us repeat once more that Hospital Progress is published for *all* the hospitals of the Catholic Hospital Association of the United States and Canada. Whether your hospital be large or small, Hospital Progress is *your magazine* and is interested in *your problems.* If Divine Providence has placed you in a small hospital you have, as you often tell us, your own problems differing from those of the big hospitals. That means that you are interested in the manner in which other institutions, with like surroundings, are solving the same problems. Tell us what you are doing and thinking. Then your neighbor may be induced in turn to give you a few pointers.

—*E. W. R.*

OUR NEW YEAR GREETINGS

We pause at New Year's dawning
To whisper our wishes in prayer:
We beg, oh! Infant Saviour
Your blessings, choice and rare.
For the Hospital Progress
And Catholic Association,
We know how faithfully they work
To help our loved nation.
So fill their days with treasures,
Opportunities and success;
And each morn of '27
Please, dearest Lord, to bless.

Sisters of St. Mary's Hospital,
Kansas City, Mo.

St. Martha's Hospital, Antigonish, Nova Scotia

THE new St. Martha's Hospital conducted by the Sisters of St. Martha was formally opened at Antigonish, on May 11, 1926, by His Honor the Lieutenant Governor of Nova Scotia. This institution is only twenty years old, but its growth has been phenomenal. From a small six-bed cottage, it has grown through successive stages of development and rebuilding to its present size—the second largest in eastern Canada.

Serves Large Rural Community

Its community is entirely rural and numbers thirty-five thousand people scattered through four counties of Nova Scotia. The hospital has increased its usefulness year after year, and appreciation of the services it renders has grown apace. When it was decided to proceed with the construction of the new building, the hospital's constituents rallied around it with assurances of support. A campaign was organized to appeal for funds with gratifying results, $125,000 being raised in voluntary subscriptions. St. Martha's, serving a large sparsely settled community, is a splendid example of the power of health education. Had it never been built, doubtless not more than 25 per cent of the 1,500 patients it treated during the past year would have gone to the larger centers for treatment. Rural communities are often much less cared for than urban centers in hospital matters and they lose as a consequence much of the health education that a hospital inevitably spreads.

The hospital in Antigonish will be enabled from its new headquarters to increase its educative as well as its curative work. It is thus carrying on a distinctively pioneer work in eastern Canada. It has completed arrangements with St. Francis Xavier's University, situated in the same town, for an affiliated course in nursing, leading to the degree of B. Sc. This is to be a five-year course and will prepare hospital executives, public health nurses, etc., besides providing for its pupils a higher academic education, which will help to make them more efficient general nurses.

Situation and Construction

St. Martha's Hospital is beautifully situated on a hill overlooking the town and harbor of Antigonish, with "Sugar Loaf" towering to the northeast. It is built in the form of the letter "H" with a frontage of 160 feet, and wings extending 100 feet. It provides accommodations for 120 adult patients, together with spacious wards for children and infants. It has been described by Canadian medical publications as "the greatest edifice ever dedicated in the Maritime Provinces to the cause of suffering humanity made possible by the unselfish and generous singleness of purpose of the people, irrespective of creed or class."

Built at a cost of $350,000, this steel and brick fireproof plant is of the most modern construction, fully equipped throughout, a self-contained unit for all hospital purposes. The partition walls are constructed of terra cotta tile manufactured in Nova Scotia. Furring tile was used on the exterior walls of all floors and interlocking tile for the pent house, skylights, etc. Plaster was applied directly to this tile, and there is no wood lath of any kind throughout the entire building which is strictly fireproof.

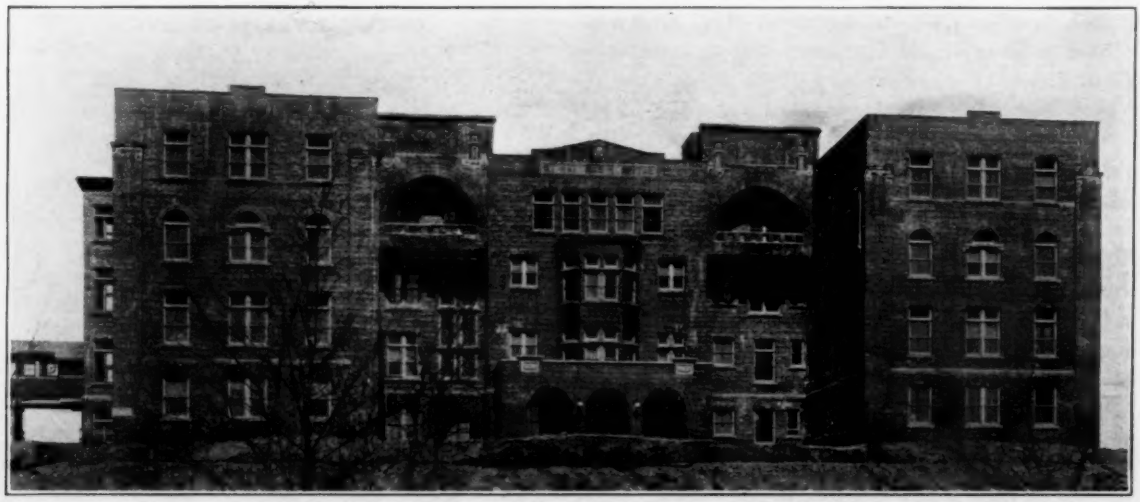
The plumbing equipment, fixtures, and heating plant are of the most modern design and especially adapted to hospital use. All windows have been fitted with permanent winter sashes, while in the operating suite, plate glass specially prepared for its diffusing qualities, has been installed in steel sash. An attractive feature of the building is the slab doors of native birch finished in mahogany stain. They are handsome in appearance and are wide enough to permit the wheeling through of a bed.

The floors for the most part are of reinforced concrete covered with cemented battleship linoleum. This secures the noiselessness which hospital efficiency demands. The floors of the service departments are of white tile.

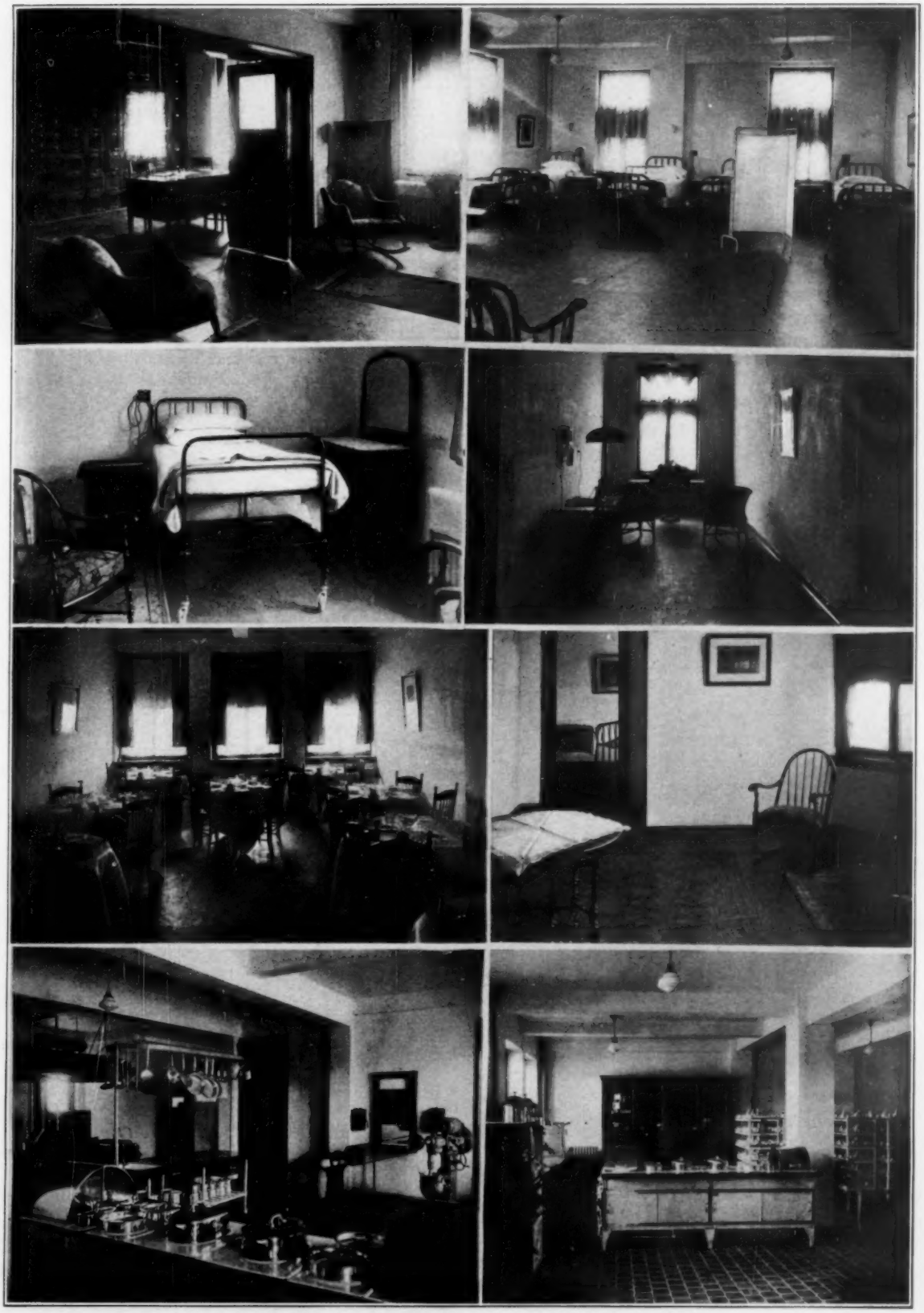
Floor Plans

The basement extends under the whole building. It provides a nurses' recreation room, store room, furnace room, high pressure steam department, and a well equipped laundry and ironing room. A section of the basement also affords comfortable quarters for the male help.

The main entrance to the hospital is on the ground floor. On one side of the main entrance hall is a reception room, on the other is the registration and general receiving office, provided with a telephone exchange giving communication between all the departments and connecting with the town service. An adjacent passage leads to a commodious vault, in the rear of the office. Across the main corridor is the record room, one side of which



ST. MARTHA'S HOSPITAL, ANTIGONISH, N. S., CANADA.



INTERIOR VIEWS OF ST. MARTHA'S HOSPITAL, ANTIGONISH, N. S., CANADA.

1926 GRADUATING CLASS, ST. MARTHA'S HOSPITAL, ANTIGONISH, N. S., CANADA.

is lined from ceiling to floor with vertical filing cabinets for the patients' history sheets. This room is connected with the doctors' consultation room by large folding doors, which permit the holding of staff meetings with ready access to necessary data. The next room is the superintendent's office. In the west wing of this floor are three rooms for the treatment of special diseases, the intern's room, the dentist's room equipped with a chair presented by the dentists of Antigonish, the social service department, lavatories, and utility rooms. In this wing also is located the physiotherapy section with its standard equipment, where electric heat and rays are used for the treatment of diseases. It is provided with a diathermy machine, a phototherapy outfit, and a violet ray apparatus. Adjacent is the hydrotherapy department with several units operated from a central control table, and leading through a doorway to the next room we find an electric and a steam cabinet. A dressing room, rest room, and toilet complete this unit.

Central Service Kitchen

The main kitchen situated in the east wing of the first floor gives a most satisfactory central service. All meals are served and transported on wheeled carriers from the kitchen to the bedside of the patient. It is commodious, well lighted, well ventilated, and with a very convenient layout. The equipment is of the very latest type, including large steam table with containers, coal range, electric dessert oven, steam cookers for soups, cereals, and vegetables, an electric cake mixer and vegetable masher, an electric ice cream freezer, potato peeler, toaster, tea and coffee urns, and a dish-washer. Adjoining the kitchen are the store rooms, cold storage, men's dining room, and a section for preparing meats and vegetables with all the usual accessories. In the same wing, south of the kitchen and connected by a passage are the dining rooms for doctors, Sisters, night nurses, and maids. The ambulance entrance from the rear of the building completes this wing. Directly opposite it is installed an automatic electric elevator which runs from basement to top floor.

The second floor has a number of private and semi-private rooms, a private suite, a twelve-bed ward, a patients' clothes room, a pharmacy, a diet kitchen, a central linen room, utility room, toilet and baths. A wing of this floor is reserved for priests with a chapel and chaplain's apartments. On this floor also is located an isolation section for the treatment of infectious diseases, containing three private rooms and bath, nurse's room provided with telephone and bath, and a kitchen.

The third floor provides the largest number of private and semi-private rooms, a twelve-bed ward, a clothes room, utility rooms, etc. The children's ward, located in the central section facing the south, is fitted out with special cots, lockers, toilet and bath.

The east wing of the fourth floor is reserved for a maternity department provided with special sterilizing equipment, private rooms, linen closets, a diet kitchen, utility room, etc. The nursery has a southern exposure, and two large windows on the corridor side permit visitors to see the occupants without entering the room. This obviates the danger of infants contracting infection from casual visitors. A specially designed bath for the little ones is installed in an adjoining room, and a balcony where their cots may be placed in fine weather is also provided.

X-Ray Department on Fourth Floor

In the west wing of the fourth floor is located the x-ray department, which is somewhat isolated from the other sections of the floor. This consists of a general radiography room, transformer and operator's booth with two dressing rooms, a fluoroscopic room containing a horizontal and vertical fluoroscope, a film viewing room, developing room, a splint and cast room where all fractures are cared for, and a rest room. Directly across the main corridor from the x-ray department is the pathological laboratory equipped to do all serological, bacteriological, chemical, and metabolic work.

The operating suite is located in the central section of the top floor. This unit consists of a major operating room, a minor operating room, an eye room, an ear and throat room, doctor's room equipped with lockers, knee-control lavatory, etc., and a sterilizing room. Both major and minor operating rooms are provided with special lighting facilities, both natural and artificial. The walls are tiled with gray sani-onyx to a height of six feet.

The roof of the building is of five-ply tar and gravel, supported on a reinforced concrete slab. Numerous small balconies adorn the exterior besides adding to the utility of the interior. On the western side of the structure, sun-parlors extend from ground to roof, affording additional facilities for enjoying the sunshine. A covered bridge with numerous glass windows connects the second floor of the new building with the second floor of the old hospital which has been recently remodeled and fitted out for a nurses' home. This also adds to the appearance as well as the utility of the plant.

The lighting, like the other modern features, has been installed with an eye to the greatest possible efficiency. In the wards floor lights have been provided to prevent the patients' eyes from glare when they are visited during the night. Illumination is by central and bracket lights, and the wall fixtures are equipped with means of using special apparatus that might be necessary for special treatments and examinations. The operating and specialist's rooms are provided with lights of a type that will insure satisfaction and promote efficiency.

The silent signal system gives most satisfactory service. The tinkling hand bells and the still more annoying sounds of the electric gong, a source of considerable disturbance to the patient, have been eliminated. At each bedside in the new hospital is an electric button attached to a cord, the pressing of which causes red signal lights to glow in various parts of the floor. This indicates to the nurse just where her attention is required, and the light burns until the patient's bed is reached, when the pressing of another button turns it off.

Color Schemes in Decoration

The private rooms and wards are furnished in definite color schemes according to the best hospital ideas, bedside screens, window hangings, coverings, and rugs harmonizing very effectively. The usual institutional mark has been replaced by a more home-like appearance. Wards and rooms through the building are furnished with adjustable beds operated easily and quickly as the comfort of the patient may require. Each bed is provided with a combination steel bedside table and commode. This new combination bedside unit is both convenient and sanitary. The table can be adjusted to any required position and folded after use.

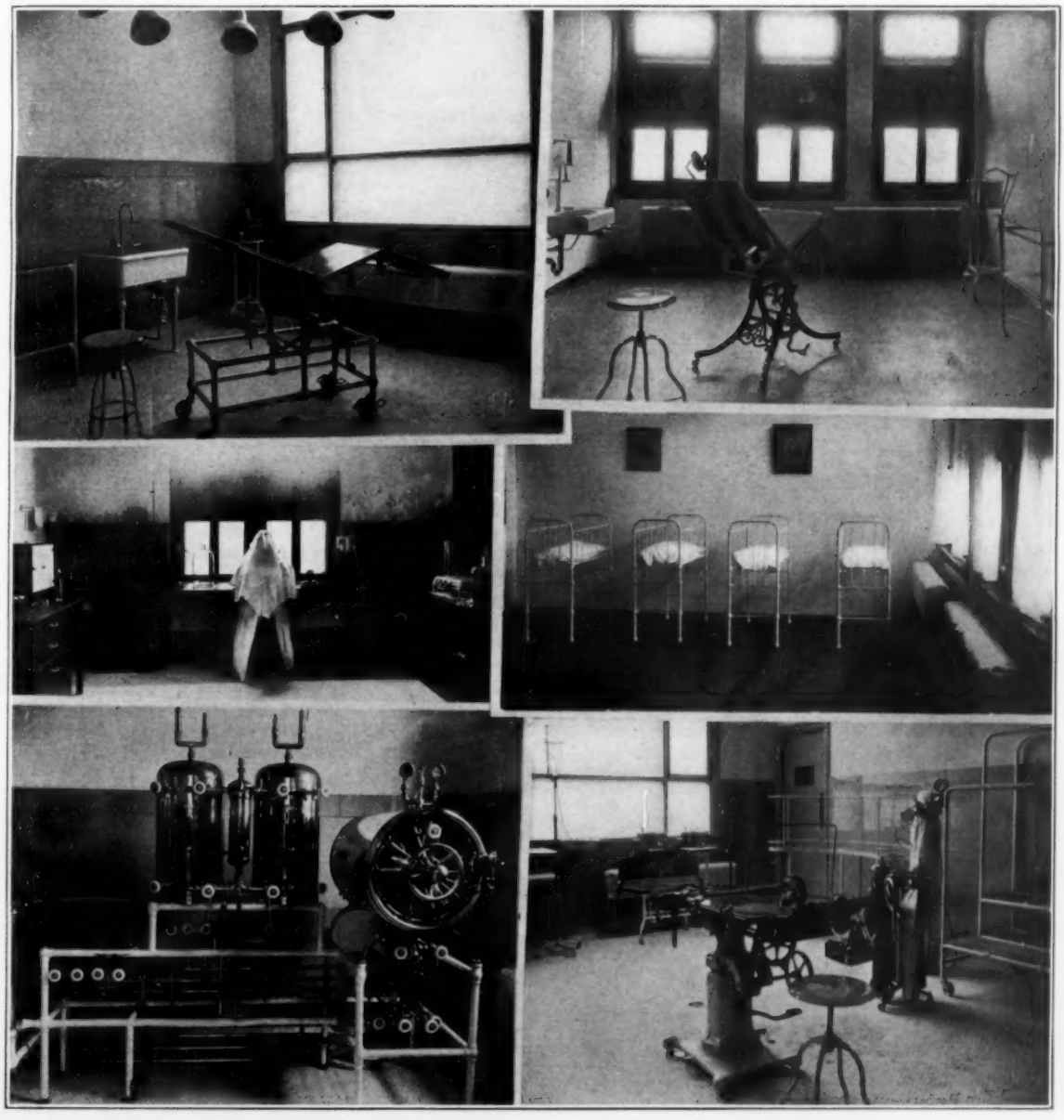
On the whole, this new building rising into existence during a period of industrial unrest and stress, is a tribute to the generosity and intelligence of the people of eastern Nova Scotia. It proves with more eloquence than empty words that a fine and enduring spirit of their forefathers still lives amongst them—a spirit which it is to be hoped will live on, and abide with them for all time.

TWO DEPARTMENTS AT ST. MARTHA'S HOSPITAL[1]

W. F. McKinnon, M.D.

I HAVE for some time watched the progress of the Catholic Hospital Association and I have been profoundly impressed by the rapidity with which it has expanded, by the great work it has done in hospitalization, by the outstanding position it occupies, and the esteem it today holds in the medical world. I venture to say that the wonderful present efficiency attained by the modern hospital is in a large measure due to the devoted and indefatigable efforts of the Catholic Hospital Association. While its growth and influence have been so rapid, no one who has been in touch with hospital work carried on by the Catholic Sisterhoods is at a loss to understand this phenomenon. Non-Catholics who have strong views on religious questions, are one with Catholics in their admiration of the Sisterhoods as a nursing body. They

[1]Paper read at the Maritime Conference of the Catholic Hospital Association, St. Martha's Hospital, Antigonish, N. S., Sept. 1-3, 1926.



INTERIOR VIEWS OF ST. MARTHA'S HOSPITAL, ANTIGONISH, N. S., CANADA.

show their appreciation by their sympathetic and generous support, and by the confidence with which they place themselves under their care.

This is a happy augury for the future of hospitalization. I have no doubt that this future has much in store for the nursing Sisterhoods. We do not forget that the first real nursing in the middle ages was carried on by the religious orders. Many centuries have passed since that time and many vicissitudes have fallen upon these noble women. It is, therefore, a matter of gratification that they are again assuming an ascendancy in this great humanitarian work.

Ethylene a Modern Anaesthetic

The first thing I wish to speak of is our ethylene equipment. Ethylene as you know is one of the latest general anaesthetics. It is hard to restrain one's enthusiasm in speaking of the virtues of this excellent anaesthetic. While we have by no means forgotten or neglected our good friend, ether, there are so many occasions when the use of ethylene makes the surgeon's burden easier, and the patient's outlook brighter, that we have to look upon ethylene as one of the greatest factors for good in our institution. An anaesthetic is always dreaded. The fear of it has kept many sufferers from seeking relief from their miseries. The reputation of ethylene has so spread in this hospital constituency that patients come for operation demanding ethylene as their anaesthetic. It is pleasant to take. I myself was curious to know its action, and I tested it out when I had a tooth extracted. I was off the table within two minutes, with absolutely no discomfort and able to visit my patients. A member of my family had occasion to have the tonsils removed. The patient was awake within three minutes of the end of the administration with the tonsils removed and expressing delight at feeling so well. For prolonged operations, our experience has been equally satisfactory. In our experience, complete relaxation is always obtained; the patient remains warm and dry; the salivary glands remain in action; and there is no bronchial irritation. Ethylene has been used with great satisfaction in acute coryza, empyema, acute and chronic bronchitis, asthma, advanced tuberculosis of the lungs, and in chronic Bright's disease complicated with articular rheumatism. I have had it recently used for teeth extraction and the patient was able to leave the hospital within a few hours. I may say that in not a single case has the patient had to be strapped or restrained in any way. The patient does much better if a hypodermic of morphine and atrophine is given an hour before the operation. Sometimes the patient becomes too comfortable and respiration requires a little stimulation. This can be done effectively by the use of a little CO_2. Formerly when we had three or four cases under ether anaesthesia, special nurses would be required for the post anaesthetic period; when ethylene is used none are required. Again, in addition to vomiting the patients were subjected often to severe gas pains, and again these features are practically eliminated. Ethylene is a more powerful anaesthetic than N_2O, and a given quantity in the nerve cells produces a deeper anaesthesia. This is equivalent to widening the anaesthesia range. For this reason it is possible to produce a quiet anaesthesia in children where the metabolic rate and the oxygen requirements are high. Such an anaethesia could not be produced by nitrous oxide. Our anaesthetist has furnished me with some cases, a few of which I shall cite:

Case 1: A woman, aged 45, had ether once before and suffered greatly from after effects. On being visited two hours after taking ethylene she was enjoying a glass of water and said she felt fine with no unpleasant after effects.

Case 2: A man, aged 30, never had an anaesthetic before. The operation lasted 30 minutes; after removing the cone the patient appeared quite bright and asked to see his appendix; seen six hours later, he said he was very hungry.

Case 3: A man, aged 40, remained asleep five minutes after cone was removed. Seen two hours later he said he suffered from pain in incision. After a hypo he slept two hours; he did not complain after.

Case 4: A girl, aged 14, suffering from peritonitis, pulse 140, breathing rapid; operation lasted 40 minutes. On awakening on table, patient vomited. She took water the following day and is doing well.

The Physiotherapy Department

The second matter I wish to deal with is our physiotherapy department. This addition to our armamentarium has attracted attention and visiting physicians have been loud in their praises of this department. It consists of the electro-therapeutic, embracing diathermy, ultra-violet ray, thermotherapy, and electro-bath; and the hydrotherapeutic department which embraces the Turkish bath, sedative bath, Scotch douches, and arm and leg bath. This department has been in operation since March 24th, 1926, and 52 cases have been treated.

Personally I have great faith in this department. There are certain classes of patients that are especially benefited, such as, neurasthenic, rheumatic, kidney, and alcoholic cases. So far we have treated neuritis, neurasthenia, anemia, insomnia, arthritis, eczema, psoriasis, alcoholism, nephritis and rheumatism; all were relieved and some were cured. This treatment is of course given in conjunction with medical treatment. In a marked case of anemia, under my observation, the addition of air-cooled ultra-violet irradiation gave most gratifying results. On admission the patient's red blood count was 2,300,000 and haemoglobin 35 per cent; after ten days' treatment the red blood count was 3,800,000 and haemoglobin 53 per cent. This patient made a rapid recovery.

In a neurasthenic case, that I had treated with indifferent success for some time, the patient on being given hydrotherapeutic treatment, improved rapidly. In several alcoholics, the sedative bath was of great assistance in quieting the patient and promoting sleep. I have at present in the hospital a patient who has been suffering for many months from articular rheumatism. She had to be carried into the hospital. After two weeks' treatment of physiotherapy, she is greatly relieved and able to walk a short distance. Septic wounds are benefited by a mild exposure to ultra-violet rays. An intractable septic arm case at present in the hospital, showed marked improvement after the application of ultra-violet rays.

I could exhaust your patience on this subject, and as I am trying to be as brief as possible, I shall rest here with the assertion that physiotherapy has a great future, and that the institution that neglects its employment, is not taking advantage of a very important aid for the relief of many sufferers.

WE BEG YOUR PARDON

Through an unfortunate mistake, the exterior views of Mercyville Sanitarium, Aurora, Ill., and St. Mary's Hospital, East St. Louis, Ill., at the head of the articles on these institutions in our last month's issue were interchanged.

Indiana Conference of the Catholic Hospital Association

DELEGATES, INDIANA CONFERENCE, CATHOLIC HOSPITAL ASSOCIATION.

THE annual meeting of the Indiana Conference of the Catholic Hospital Association was held at St. Joseph's Hospital, South Bend, Ind., Nov. 16-18, 1926. Sisters from nearly all the hospitals of the Indiana Conference enjoyed the cordial hospitality of St. Joseph's Hospital and manifested great interest in the papers and discussions.

The program began on Tuesday, Nov. 16, with Solemn High Mass celebrated by Very Rev. Geo. J. Finnegan, C.S.C., provincial of the Congregation of the Holy Cross, and a sermon by Rev. John Cavanaugh, C.S.C., Notre Dame University. At the opening meeting Hon. Chester R. Montgomery, the mayor of South Bend, delivered an address of welcome. The following papers were read during the two days of the convention, each being followed by a discussion:

"The Relation of the Staff to a Hospital," R. L. Senenich, M.D., St. Joseph's Hospital, South Bend; "The Relation of the Hospital to the Staff," E. L. Moorehead, F.A.C.S., chief of staff, Mercy Hospital, Chicago; "Interns and the Hospital," C. W. Rauschenbach, M.D., St. Margaret Hospital, Hammond; "Hospital Liability," James A. Murphy, attorney, Medical Protective Co., Fort Wayne; "Autopsies," V. A. Lapenta, M.D., president of Staff, St. Francis Hospital, Indianapolis; "Problems of the Private Duty Nurse," H. O. Bruggeman, F.A.C.S., St. Joseph's Hospital, Ft. Wayne; "Reminiscences of Nursing," Mary Walsh, R.N., instructress, St. Mary's Mercy Hospital, Gary; "Care of the New-Born from a Nurse's and Hospital's Standpoint," L. P. Drayer, M.D., St. Joseph's Hospital, Ft. Wayne; "Aspirations of Indiana Nursing Schools." Ven. Sister Flavia, superintendent of nurses, St. Mary's Mercy Hospital, Gary; "Alumnae Associations," Rev. Matthew Schumacher, C.S.C., Notre Dame University; "Legal Aspects of Hospitalization," Dudley S. Wooden, attorney, professor, Notre Dame University; "Fire Prevention in Hospital," Ray Knoblock, chief, fire dept., South Bend.

Entertainment for the delegates was not lacking. They were taken for a tour of the city of Notre Dame University and St. Mary's Academy. On Tuesday evening they enjoyed a social hour at St. Joseph's Hospital, and on Wednesday they assembled for a group photograph.

On Wednesday morning a clinic and program was held under the auspices of St. Joseph County Medical Society.

On the last evening of the conference a special organization meeting was held of the Sodality of St. Joseph Hospital attended by graduate as well as student nurses. Father Garesché gave an address, explaining the purpose and ideals of the Sodality and four sections were formed for the missions, catechetical study, good reading, and sociability and devotion respectively.

The discussions of the conference were participated in by Father Moulinier and Father Garesché, as well as by a number of Sisters and some members of the hospital staffs. Resolutions were passed thanking St. Joseph Hospital for the kind hospitality and also extending appreciation to all who helped to make the conference a success. The officers elected are as follows:

President—Sr. Mary Odilo, St. Joseph's Hospital, Fort Wayne, Indiana.

Vice-President—Sr. Mary Florina, St. Margaret's Hospital, Hammond, Indiana.

Secretary-Treasurer—Sr. M. Ann Patrice, St. Joseph Hospital, South Bend, Indiana.

Executive Committee—

Sr. Mary Adolphine, Holy Family Hospital, La Porte, Indiana.

Sr. M. Humberta, Sacred Heart Hospital, Garrett, Indiana.

Sr. M. Imeldine, St. Anthony's Hospital, Terre Haute, Indiana.

The County Medical Society held its meeting jointly with the Catholic Hospital Association on the second morning and in the evening of the same day the dinner of the County Medical Society was held at the K. of C. club at which Father Moulinier and Father Garesché were guests and the former gave an address congratulating the County Medical Society on its effective work in helping to promote better hospitals.

Autopsies[1]

Vincent A. Lapenta, M.D., Senior Surgeon and President of the Medical and Surgical Staff, St. Francis Hospital, Indianapolis, Ind.

THE title of this brief essay, as stated on the program, may easily lead one to believe that a discussion of post-mortem technique and of pathological investigation is intended. While much could be written on this phase of the subject, especially since many autopsies are conducted in such perfunctory manner as to be of little value either to the case in hand or to the advancement of medical science, it is not the technical details that I shall discuss, but rather I shall attempt to point out the great necessity of performing autopsies in as large a number of cases as possible, as a fundamental necessity for the true scientific development of the medical art.

We may say without fear of contradiction, that medicine began to become scientific only when it made pathological anatomy the basis for the investigation of disease and the touchstone of clinical symptomatology and treatment. We cannot, therefore, begin to restate the fundamental value of pathological anatomy without first turning our minds in veneration to the genius of Giovanni Battista Morgagni. By his lifelong teaching at Padua and principally through the publication of his "De Sedibus et Causis Morborum per Anatomen Indagatis," a book published in Venice in 1762, he laid the foundation of modern scientific medicine. It is on this rock that the great labors of so many illustrious masters throughout the world, have built the towering edifice against which all the waves of ignorant cults and sects beat in vain.

It is in the post-mortem study that diagnoses are proved and efficacy of treatment weighed. In late years, with the advancement of physiological science, there has been a little relaxation in the study of pathological anatomy. So much stress has been put on functional pathology and functional diagnosis and functional treatment, that the conceptions of organic lesions are becoming quite hazy and we are well in danger of sinking back into a state of complacent empiricism.

It is hardly necessary to speak of the imperative necessity of autopsies in all cases of sudden deaths due to violent causes. We should be thankful that for medico-legal reasons, the coroners carry these out, and can only regret that the work is not coordinated with the departments of pathology of medical schools where the material would become of teaching value as well as continue to be of medico-legal interest.

Let us now attempt to look into the question of autopsies from the practical side of our daily hospital practice. I believe that it is hardly necessary to say much more regarding the scientific value of post-mortem examinations and the inestimable lessons to be derived for the development of our diagnostic skill. A word, however, should be said in regard to the protection of our professional reputation. How often the relatives of a patient, succumbing soon after a very major operation, are inclined to regard the death as due to bad surgery and not due to unavoidable complications or to organic lesions in vital organs, rendering recovery improbable? Mrs. Jones had a Wertheim hysterectomy for carcinoma. She died three days later with all the signs of coronary thrombosis and cardiac dilatation. The relatives may say that death was due to internal hemorrhage—to incompetent surgery. The autopsy could have shown the cause of death, and the good name of the hospital would not have suffered. Mr. Smith succumbs to a broncho-pneumonia following a prostatectomy. If no autopsy is made, some one could claim that it was due to peritonitis, resulting from incompetent surgery. Examples could be multiplied ad infinitum. Of course, it may be uncomfortable to find that John Smith operated upon for appendicitis, really had lobar pneumonia, and that Miss Blank, operated upon for the same thing, had typhoid fever, but the fact that autopsies can uncover such mistakes will serve to make one cautious and disinclined to snapshot diagnosis.

I have already stated that an autopsy performed in a superficial, perfunctory manner is worth very little, if it is not, indeed, worse than none at all, considering the misleading information to which it may give rise. Worth while post-mortem examination must be performed with the assistance of a competent clinical pathologist and, when possible, turned over to his complete charge. While great care must be given to the detection of all macroscopic lesions—which must be described according to the best pathological nomenclature, microscopic studies must be made of all important lesions and these studies, to be of any value, must be under the control of a trained man. There are, of course, occasional cases where the gross findings represent such classical lesions as to render detailed histological study unnecessary.

For the close of this modest dissertation, I have left a burning problem that I have not been able to solve satisfactorily, that is, the question of how best to get consent to hold a post-mortem. In private practice it is almost an unsurmountable obstacle—it is next to impossible to obtain permission. This seems to be particularly true of surgical cases. The relatives generally feel that the patient has had an "autopsia in vivo," at least as far as the main complaint is concerned, and consequently, they do not look with much favor on a post-mortem. I confess that, having used, in vain, all the arguments imaginable to convince the people of the great need of consenting to autopsies, I feel considerably discouraged at the outlook for the future. Some sort of educational campaign among the laity may do some good. I believe the insurance companies could render great service in this connection by educating their policyholders.

I desire to commend Father Nickels for including this timely subject in the program, though he has not made a happy selection of the essayist. I hope that the discussion will point to some easy method of obtaining consent to necropsies. There is, however, one benefit that follows any discussion of the value of autopsies, and that is a realization that the greatness of modern scientific medicine rests on pathology more than on any other science. It is in the domain of pathology that all other medical sciences serve the true progress of our art.

Let us, then, continue with unrelenting zeal, our efforts to contribute our little grains of sand to its great future edifice. I know of no worthier service to medical science and humanity.

[1]Read at the fifth annual meeting of the Indiana Conference of the C. H. A. held at South Bend, Ind., Nov. 16-18, 1926.

It is with joyful and grateful hearts that we extend our Christmas wishes to HOSPITAL PROGRESS and every one connected with it.

May the dear Infant Jesus reward you and all your associates with the blessings which He has promised to those who would do anything, even the smallest act of charity, to alleviate the sufferings of His chosen friends, the sick. Sincerely in Christ, *Sisters of St. Joseph,*

St. John's Hospital, Salina, Kansas.

The Dietitian's Department

Conducted by Florence H. Smith, S.B., Department of Nutrition, St. Mary's Hospital, Rochester, Minn.
Suggestions and Correspondence Welcome.

THE RELATION OF THE DIET TO NEPHRITIS AND HYPERTENSION

Norman M. Keith, M.D., Division of Medicine, Mayo Clinic, and Florence H. Smith, S.B.

IN a preceding paper the selection of food in general and the principles involved in building up any normal maintenance diet were considered. These same general principles guide us in planning diets for patients with nephritis, but there are other factors to be considered. In the past many persons, including certain physicians, have been inclined to regard albuminuria, particularly if associated with increase in blood pressure, as diagnostic of Bright's disease. The patients, in such cases, have been given unfavorable prognoses and have frequently been placed on a milk diet, or at least on a diet containing a large amount of milk.

The presence of albumin in the urine should always receive serious consideration, especially if the blood pressure is elevated. Bright's disease may or may not be present. It is the physician's duty to make an accurate diagnosis, and to distinguish between the relatively harmless form of albuminuria and the more serious form. This requires careful study of the urine and blood pressure, a complete investigation, particularly of the heart and blood vessels of the body in general, and of the retina of the eye. Investigation for evidence of dropsy or anemia should also be made. Even with all this data it is usually necessary to employ various tests of renal function, such as examination of certain chemical constituents of the blood, and the ability of the kidney to eliminate certain dyes, salt, or water. The power of the kidney to pass concentrated urine if the patient is on a diet low in fluid content and likewise its ability to excrete dilute urine after large quantities of water have been ingested is also a most important diagnostic point. With such data at hand it is usually possible for the physician to make an accurate diagnosis and to plan rational treatment. In many cases of nephritis a milk diet is not sufficient. Frequently the kidney is unable to handle properly proteins, salts, or water individually or in combination. Therefore, if enough milk is given to supply the calories required, too much protein, salt, and water are also given.

In this paper the term "nephritis" is used in its broadest sense, and no attempt is made to differentiate the different types of degenerative, vascular, and inflammatory disease of the kidney. From the patient's standpoint it is necessary only to regard nephritis as a condition in which one or more of the functions of the kidney are impaired; the diet is planned to spare, so far as possible, the injured kidney and to avoid over-strain on its excretory function. As a rule, the protein content of the nephritic diet is reduced since most protein decomposition products are excreted through the kidney; but less than 40 gm. a day is rarely given because the body requires about this amount to prevent destruction of tissue. Water is ordinarily not restricted unless there is edema, but salt is kept at a low level. If there is retention of protein derivatives, such as urea, large amounts of fluid are usually given with the food in order to wash out these poisonous substances.

Patients with hypertension, even though they may not have nephritis, are usually given food which is relatively low in protein, salts, condiments, extracts, and all irritants. The exact cause of hypertension and its relation to diet has not been definitely determined, but it seems advisable to spare the kidney and arterial system from as much work and irritation as possible, and to encourage temperance in eating. The diets for these patients conform to all the rules of a normal diet and should be followed as closely as possible.

Selection of Food for Nephritic Patients

Often when a patient with nephritis enters the hospital he is placed on a diet which is calculated to meet the requirements of the average individual at rest in bed. This diet contains approximately 40 gm. of protein, 1,500 calories, between 1,200 and 1,400 gm. of water in the food, and 7 to 8 gm. of salt. It is estimated that there are 2 gm. of salt naturally in the food and approximately 5 gm. are added during preparation. No extra salt or pepper is allowed on the tray. No other seasonings or condiments are used except a small amount of vinegar. Additional fluids up to 1,200 c.c. are allowed unless otherwise ordered. As the calorie requirement and the ability of the patient to use protein food is determined, the diet is adjusted by the physician to meet the patient's requirements. Protein is added in any form desired and the calories adjusted by the addition or subtraction of carbohydrate or fat.

The importance of vegetables in the diet cannot be over-emphasized. Canned vegetables are available in all parts of the United States and Canada. These are wholesome and palatable and should be used freely when fresh vegetables are not available. It is not necessary to purchase special brands of canned vegetables. A brand suitable for use by the family is preferable. Home canning is a desirable and economical method of preserving many foods by means of which their use is distributed over seasons and in localities where they are not available fresh. There is no question that to most people fresh fruits and vegetables are more palatable than the canned product. The family should eat plentifully of the fresh fruits and vegetables in season, not cutting down on their use in order to have a supply to can. Provisions for canning should be made whenever possible by planting gardens to yield a succession of fresh vegetables for daily use and a surplus for canning. The valuable mineral and vitamin content of fresh food is not lost if proper methods of canning are employed. Other methods of preservation should be considered before canning is done. Certain root vegetables as beets, carrots, turnips, squash, and pumpkin, may be stored in cellars for winter use. It is often helpful to can some of these winter vegetables during the summer when they are young and tender. These may be used in the early spring when the stored vegetables have lost their fresh flavor. If fruits and vegetables have to be purchased for canning the cost should be compared with commercially canned goods and fresh products out of season to determine the advisability of home canning. Full information regarding the canning of fruits and vegetables at home may be obtained from the U. S. Department of Agriculture, Farmers' Bulletin Documents, Government Printing Office, Washington, D.

C., at 5 cents a copy. If the diet is ordered salt-free, vegetables canned without salt may be purchased through your home grocer. When these are not available, fresh vegetables should be used if possible.

Fruits, fresh, or canned, are often advised instead of made desserts. These are particularly helpful in combating hunger when the caloric intake is low, and in cases of constipation when additional bulk is required.

The choice of bread is unlimited for the nephritic patient. Breads made from whole grains contain more mineral salts than the highly milled products. But if fruits and vegetables are used plentifully it is not necessary to use whole wheat bread exclusively. White bread, rye bread, graham bread, and corn bread are all wholesome foods.

Butter and butter substitutes may be used as allowed on the diet. A standard butter cutter cuts a pound of butter into forty-eight squares. Each square contains approximately 10 gm. of butter. If the food is to be served without salt, the salt may be washed from the butter, or sweet butter used.

Bacon may be used by the nephritic patient unless the diet is ordered salt-free. Bacon contains a relatively low amount of protein and a large amount of fat. Eggs contain protein and should be used as specified on the diet order. So far as we know red meats are no more harmful to the nephritic patient than white meats if equal amounts are used. It is the quantity of protein food rather than the quality that is limited for the nephritic patient. Meat, soup, broth, and gravy should be omitted as they contain meat extractives in concentrated form. Twenty per cent cream is sold on the market as coffee cream, and may be purchased from the dairy or skimmed from milk which has stood in a favorable temperature for twelve hours or more. Forty per cent cream is sold on the market as whipping or heavy cream. Mayonnaise dressing made by any standard recipe is approximately 85 per cent fat. The traces of carbohydrate and protein in this may be disregarded. Either lemon or vinegar may be used in making salad dressings. Milk is valuable food for the young and should be used in all diets when the protein and fluids allowed are sufficient. Cereal is a valuable food when the amount of carbohydrate in the diet exceeds the amount necessary for vegetables, fruits, and cream. When the diet is ordered salt-free prepared cereals containing salt must be avoided.

It is difficult for the average patient to use many of the recipes of calculated food value when a diet order must be followed. A wide variety of simple foods, well cooked and nicely served, will prove more satisfactory. If the use of coffee, tea, and cocoa is prohibited many patients learn to enjoy Kaffee Hag. Directions for making coffee are followed in preparing this beverage. Postum may be used if desired. Vinegar may be used in reasonable amounts. Spices such as pepper, mustard, et cetera, should be used sparingly, if at all. The amount of salt and water allowed will be prescribed by the physician in charge.

How the Diet is Planned

Much of the drudgery of planning and calculating the diet for each day is eliminated if a simple plan of selection is followed. The physician designates the amount of carbohydrate, protein, and fat allowed in the diet. In doing this he covers the first three points of our diet score card.[1] It remains then for the dietitian and the patient to plan a diet which will hold all other factors of the diet normal. This is done by using a foundation diet as a basis for the daily three meals.

[1]Food Selection for the Hospital Patient, Florence H. Smith, Hospital Progress, December, 1926.

A Foundation Diet

Each day's menu:

Two servings (200 gm.) of 5 per cent vegetables.
Two servings (200 gm.) of 10 per cent vegetables.
One serving (100 gm.) of 10 per cent fruit.
Two servings (200 gm.) of 15 per cent fruit.
One serving (100 gm.) of 20 per cent fruit.
Three slices (60 gm.) of bread.
One serving (100 gm.) of potato.
One serving (20 gm. dry weight) of cereal.

There are approximately 20 gm. of protein in the foundation diet. The amounts of carbohydrate it contains vary with the kinds of fruits and vegetables selected. If the calories prescribed are low the leafy vegetables of low carbohydrate values may be used. This food may be divided among the three meals in any way the patient desires provided all the food is consumed within the twenty-four hours.

To build a 40 gm. protein, 1,500 calorie diet with this foundation diet the following foods may be added for breakfast, dinner, and supper:

Breakfast

One egg (50 gm.).
One-fourth glass (60 gm.) cream, 20 per cent.
One-half square (5 gm.) butter.

Dinner

One serving (100 gm.) of 20 per cent fruit.
One cup (200 gm.) of cream soup.
One-eighth glass (20 gm.) of 20 per cent cream.
One square (10 gm.) of butter.

Supper

Two tablespoonsful (30 gm.) of cream sauce.
One square (10 gm.) of butter.
One-eighth glass (20 gm.) of 20 per cent cream.

Written in the form of a menu for a day the diet which contains 40 gm. of protein and 1,500 calories appears as follows:

Breakfast

One orange (medium size).
One serving of oatmeal.
One egg.
One slice of toast.
One-half square of butter.
One-fourth glass of 20 per cent cream.

Dinner

One cup of cream of corn soup.
One baked potato.
One serving of tomato.
One serving of carrots.
One serving of pear and lettuce salad.
One banana.
One slice of bread.
One square of butter.
One-eighth glass of 20 per cent cream.

Supper

One serving of creamed asparagus.
One serving of beets.
One serving of apple salad.
One serving of stewed prunes.
One slice of bread.
One square of butter.
One-eighth glass of 20 per cent cream.

Daily menus planned for the patient are of doubtful value because the food selected is often not available at the time indicated. It is, therefore, important that the patient should learn to substitute one food for another of equal value, thus keeping his diet constant and avoiding the monotony that results from following a diet prescription if a knowledge of food values is lacking. The following list may be helpful in selecting foods for a diet which contains 40 gm. of protein. These protein foods should be used as additions to the foundation diet which contains approximately 20 gm. of protein.

Protein Foods in a Diet Containing 40 Gm. of Protein

Day	B'kf't.	Dinner	Supper
Sun	Bacon	Veg. soup	Chicken
Mon	Bacon	Veg. soup	Two chops
Tues	Egg	Cream soup	
Wed	Bacon	Small steak	Veg. soup
Thur	Egg	Veg. soup	Ice cream
Fri	Egg	Fish	Pea soup
Sat	Bacon	Cream soup	

Vegetable soup, with vegetable stock as a basis rather than a meat stock, may be used whenever desired. It is a pleasant addition to a meatless meal. All meat soup, broth, and gravy should be avoided as these contain meat extractives in concentrated form.

Fruits and Vegetables in a Diet Containing 40 Gm. Protein

Besides the eight servings (800 gm.) of fruits and vegetables used as a basis for the diet, potato or potato substitutes, such as rice, macaroni, spaghetti, corn or hominy, are allowed once a day. Lima beans, navy beans, and baked beans should be avoided unless protein in some other form is subtracted. Green peas may be used but only one-half serving, as peas contain considerable protein. Vegetables should be selected from either the 5 or 10 per cent group. One vegetable may be creamed each day. Salads may be served twice each day. These may be made of fruit or vegetable or a combination of both. If a cooked salad dressing is used the food value may be disregarded.

Desserts in a Diet Containing 40 Gm. of Protein

The dessert should be fruit of which a wide choice is allowed. Fresh fruits should be used whenever possible, but dried and canned fruits are permissible. All rich desserts and pastries should be avoided. Simple fruit puddings containing not more than 20 gm. of protein may be used. The following are examples: Fruit jello, fruit tapioca, escalloped fruits, as apple betty, rice with fruit, fruit ices, fruit whips.

Bread and Cereals in a Diet Containing 40 Gm. of Protein

The bread may be white, whole wheat, rye, or graham. The amount is limited to one slice each meal. A roll or biscuit of the same size may be taken in place of a slice of bread. Breakfast cereals of all kinds may be used. The food value of a serving of cereal, one potato, and a slice of bread is approximately the same. They may, therefore, be substituted one for the other. A list of substitutes for one slice (20 gm.) of bread, is given elsewhere in this paper.

Beverages

Coffee, tea, cocoa, and chocolate must be avoided. Postum or Kaffee Hag may be used as beverages. Sugar (not to exceed two lumps) may be used for the beverage. One teaspoonful of sugar is allowed for the cereal.

Diet Substitutions

Carbohydrate equivalents: It is important that the fuel value of the diet be kept constant. The substitution of one form of carbohydrate food for another is often necessary. The following tabulations will serve as a guide when substitutes are needed:

Substitutes for One Slice (20 Gm.) of White Bread

Three servings (300 gm.) of 5 per cent vegetable.
One and two-thirds servings (166 gm.) of 10 per cent vegetable.
One-half serving (50 gm.) of 20 per cent vegetable.
One serving (100 gm.) of 10 per cent fruit.
Two-thirds serving (66 gm.) of 15 per cent fruit.
One-half serving (50 gm.) of 20 per cent fruit.
One-half serving (12 gm.) of dry cereal.
One slice (20 gm.) of rye bread.
One slice (20 gm.) of whole wheat bread.

Protein Equivalents

Variety is added by occasionally substituting meat or other food having a food value of 6 gm. of protein and 6 gm. of fat, when an egg is allowed in the diet.

Substitutes for One Egg

One inch cube (25 gm.) of American cream cheese.
One glass (200 gm.) of milk.
One cup (200 gm.) of cream soup.
One serving (100 gm.) of ice cream.
One serving (100 gm.) of custard.
One serving (25 gm.) of lamb chop (lean meat).
One serving (33 gm.) of boiled ham.

The following foods contain varying amounts of carbohydrate and fat. The protein in the servings indicated equals the protein in one egg. The carbohydrate may be disregarded but the fat should be adjusted by omitting butter from the diet as indicated:

Twenty almonds (30 gm.) deduct two squares of butter.

Six Brazil nuts (36 gm.) deduct two and one-half squares of butter.

Eighteen halves of English walnuts (37 gm.) deduct two and one-half squares of butter.

Three-fourths ounce butternuts (23 gm.) deduct two and one-half squares of butter.

Twenty pecans (60 gm.) deduct five squares of butter.

One ounce hickory nuts (35 gm.) deduct two and one-half squares of butter.

Forty filberts (40 gm.) deduct two and one-half squares of butter.

It is often convenient and sometimes necessary to use substitutes for butter in the diet. The following is suggested:

Substitutes for One Square (10 Gm.) of Butter

Two teaspoonsful (9 gm.) of salad oil.
Two teaspoonsful (12 gm.) of mayonnaise.
One and one-half strips (15 gm.) of bacon.
Two tablespoonsful (25 gm.) of 40 per cent cream.
One-fourth glass (50 gm.) of 20 per cent cream.

The patient is advised to keep a record of the food served to him at the hospital. These diets together with the instructions given by physicians, dietitians, and nurses will enable the patient to continue the diet after he leaves the hospital.

St. Joseph's Hospital, Guelph, Ontario[1]

ST. Joseph's Hospital, Guelph, Ont., is situated on the southwestern boundary of the city within five minutes' walk from the main car line. This ideal location furnishes the repose of country atmosphere together with every possible city convenience.

The original building was erected in 1861 by the Community of the Sisters of St. Joseph, diocese of Hamilton, under whose judicious care it has gradually grown. In 1878 it was first remodeled and later in 1895 a fine new building was added which met the requirements of the city for some time. The problem of constructing a new, modern, up-to-date hospital which would utilize to the best advantage the old building was placed in the hands of specialists and the new building was completed in 1925.

The existing building to which the additions were made was in the form of the letter "U". After considering all possible lines of extension it was finally decided to extend the two wings to the south as this would give all rooms sunlight and a fine outlook across the country, which slopes gradually away from the institution in this direction. The space between the existing wings was only 44 feet and with these extended it was felt that the court would be too narrow. It was, therefore, decided to make the extensions at the angles shown on the plans, thus increasing the sunlight and improving the view from the rooms in the court.

[1]Reprinted from "The Canadian Hospital."

The ground slopes gradually to the southwest and consequently brings the basement floor well out of ground at this point. Located therein are nurses' sitting, class, and dining-rooms with the essential serving pantry and toilet accommodation. The first floor provides for private rooms in the west wing and public and semi-private in the east wing. The largest wards will take four beds and can be used for either public or semi-private patients as conditions warrant.

On the second floor the west wing contains the female private patients and the east wing the operating and x-ray departments.

The third floor on the wings of the old building was used for storage purposes on one side and the housing of servants on the other and was in a mansard-roof. This roof was removed and the brick walls carried up above the cornice and finished with a new flat roof. The entire third floor now provides the accommodation for nurses and Sisters, the former in the east wing and the latter in the center part and west wing.

A number of minor alterations were made on the old part of the building to provide for much-needed services. These included sink and dressing rooms, diet kitchen, nurses' stations, and increased bath and toilet accommodation. New plumbing fixtures were installed in existing toilets and baths and basins provided in all existing wards. A modern nurse call system was also installed throughout the old and new parts.

The work in general, except the solaria bays at the end of each wing, is of non-fireproof construction, the exterior walls of brick and the interior corridor walls of brick and interlocking tile. The floors are constructed of joists with wood flooring and finished with rubber in the corridors and ward. In all other rooms terrazzo floors have been used.

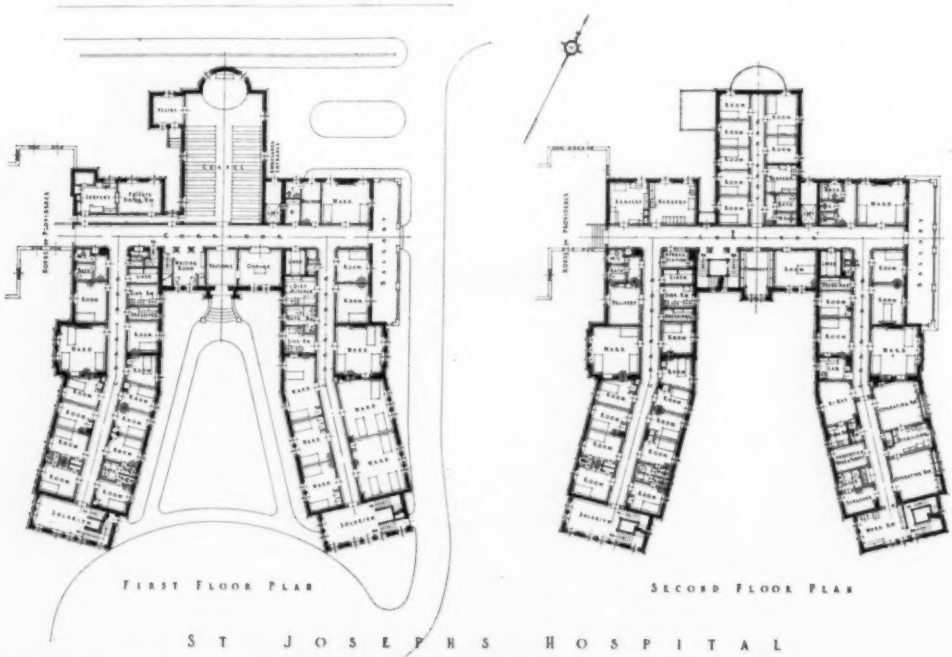
The solaria bays at the end of each wing are fireproof, the floors and stairs being constructed of reinforced concrete. These bays are cut off from the rest of the building with masonry walls and fireproof doors and so provide an excellent fire-escape at the end of each wing. The solaria situated at the end of each patients' floor together with the broad balconies on the northeast side of the building provide ample space for convalescent patients.

The finish throughout follows along the lines of the most modern hospital construction. The plumbing and electric fixtures are all especially designed for hospital purposes. There are two suites of two rooms having private toilets and a common bath between and two others wtih a common toilet only. Private rooms are equipped with telephone receptacles in addition to the general receptacles for bedside lights and nurse's call.

The exterior is of grey brick to match the existing building above the first floor. Below this the walls are of local limestone. The cornice at the eaves of the old mansard was retained and extended along the new parts. Circular headed windows were used to match the existing work and the exterior generally treated in so far as possible so that it would make a harmonious whole when completed.

The x-ray and operating rooms are excellently equipped with the latest and best appliances, while the clinical laboratory is complete in every detail.

The private rooms and wards both in design and in furnishings are characterized by simplicity and show the



ST. JOSEPH'S HOSPITAL, GUELPH, ONTARIO, CANADA.
NOTE HOW THE WINGS WERE EXTENDED AT AN ANGLE.

remarkable attention that has been given to those details and devices which are conducive to the comfort and convenience of the patient. A complete bedside unit with individual service providing for the patient a bed table together with portable lamp, is one of the many new and attractive features of the general equipment.

Some Phases of Psychiatric Nursing

Helen C. Sinclair, R.N.

HISTORY reveals that the treatment of the mentally afflicted has varied in different ages. A study of history shows that the sick in mind were not uncared for even before the time of Christ. In 860 B. C. the mentally ill were taken to the temples of Saturn and Aesculapius where they received treatment not unlike that which is used in the mental hospitals of today. Even, then, work and recreation combined with sympathy and kindness were approved forms of treatment. Following the time of Christ and down to the present time, the religious orders have contributed to the care of the mentally ill. There was a period, previous to 1792, when the sick in mind were subjected to most inhuman treatment. Much credit is due to Phillipe Pinel of France and William Tuke of England for the introduction of merciful treatment for mentally afflicted people. In our time the publication of the book by Mr. Clifford W. Beers, "A Mind that Found Itself," and the resulting mental hygiene movement has been a powerful factor in moulding public opinion in regard to mental illness, and in promoting an interest and sympathy for the mentally ill. It has also given unlimited stimulation to the study and work of prevention of mental disease and mental disorder.

Today science demands that the mentally afflicted shall have the same skilful nursing as that which is allotted to patients suffering from any bodily ailment. In a form of illness where the entire personality of the individual is involved, it would appear that the nurses who are to minister to their fellow beings while they are in this condition should have special natural qualities or characteristics in addition to those acquired during the formal course of training for psychiatric nursing. Probably the qualities which are called forth most frequently while nursing the mentally ill, and which are essential to the successful psychiatric nurse are the characteristics which impelled her into a field of work which, viewed from the human standpoint, presents little that is attractive. The nurse who is best fitted to withstand the almost constant discouragement within this branch of nursing, is the nurse who is fortified by spiritual zeal; who has an optimistic view of life; and who has a practical sympathy for suffering humanity, especially for the mentally afflicted. It is recognized by all those familiar with psychiatric work that nursing the sick in mind is one of the most difficult and arduous duties which the nurse can assume. The nurse who enters this field of work actuated by financial gain or self glorification will meet with disappointment, for the salary paid to the nurse in a mental hospital is entirely inadequate and it is seldom that she receives a word of recognition. Because of their mental condition even the patients whom she serves most faithfully are usually unappreciative and frequently abusive. The world has little conception of the quiet self sacrifice and heroic work done in this field.

The mental hospital of modern construction, located in the midst of beautiful grounds, with equipment to treat all forms of mental and physical illness, where the patients are studied by psychiatrists and the prescribed treatment carried out by psychiatric nurses exists today in many places. To infer, however, that the mental hos-

pitals have reached a degree of perfection to be desired would be foolish. In the large mental hospitals the difficulty of finding a sufficient number of suitable people to take care of the patients is an ever present worry to the administrators. A certain patient on recovery remarked that it would take a saint to take care of the majority of mentally ill patients. If that be so then there is small hope of achieving the aspired-to degree of perfection in the mental hospitals.

The following phases of the nurse's work with mental patients may be of interest and will give some idea of psychiatric nursing: Case number one: The patient was a married woman, forty-two years of age; she had always worked hard taking care of her five children and her invalid mother who, previous to the patient's illness, had a serious attack of influenza. The history of the patient's illness shows that she became irritable and nervous; she was over active and unable to sleep; she became incapable of taking care of her children. On her admission to the hospital she was violent and very abusive in her talk; her appearance was disorderly. While she was being undressed she was resistive and constantly attacking the nurses, thus rendering the procedure of undressing and bathing very difficult. She was afraid of everyone and had delusions that the Ku Klux Klan were after her. During the first month in the hospital she remained excited day and night, averaging about two hours' sleep in the twenty-four. A great part of the time she would hide under the bed or keep throwing blankets over her head. She was noisy and kept calling for her husband. She was untidy in her habits and refused to eat. The treatment of this patient consisted chiefly of continuous baths of three to four hours' duration. The patient responded well to the treatment, frequently sleeping for short periods during the bath and remaining quiet for some time after she returned to bed. Later warm packs were substituted for the continuous baths.

After the first month the patient began gradually to show signs of improvement and realized that she had been very ill; she spoke frankly of her condition. Her improvement was evidenced by her willingness to attend to herself and her interest in her personal appearance. She became interested in her surroundings, went out walking, and engaged in the usual ward activities. She ate well and gained in weight. Later she was discharged from the hospital. This shows a case where much of the nursing consisted in the faithful carrying out of the physician's orders pertaining to the continuous baths and packs which were always accomplished with difficulty as the patient was violent and resistive. The ordinary nursing procedure relative to the hygienic care of the patient was an ever present problem which had to be met in a different way, not only daily, but many times each day. Another important feature in the nursing of this patient was judicious management on the part of the nurses by leaving her to react to things as she saw them with as little as possible of unnecessary intrusion of the nurses to stimulate her already too active mind. During the patient's most disturbed period it was necessary to tube-feed her. Another symptom of her improvement was that she yielded to persuasion to feed herself, although at first she had to be reminded several times during each meal to do so. The nurse's resourcefulness in devising methods to interest the patient in the normal things in life was another important point in the nursing. Motherlike, the children were this patient's constant concern; the nurse used this means of stimulating her practical interest in life by appealing to her through her love for her children. Accordingly some of the children's clothing was brought from home and she was persuaded to mend it. Before leaving the hospital she made some garments for her children and gradually adjusted back to her former place in the community as wife and mother. The day she returned home her husband and children came to the hospital for her. They were all radiantly happy and the patient most profuse in her thanks to everyone in the hospital especially to the nurses. This was in striking contrast to her attitude of mind and her abuse of everyone, especially of the nurses, the day she entered the hospital.

Case number two: The patient was a man twenty-nine years of age. He was married and had two children. Two years after marriage his behavior changed. He became irritable and unwilling to mingle with other people. This patient was a graduate of an agricultural college; when admitted to the hospital he was taking extra courses with no goal in view, although he was not in a financial position to afford a college education without applying it as a means of livelihood. He had delusions of persecution and had an idea that the Catholics and the Mormons were after him. He thought that he had done something dishonest. Several days after admission the patient became quite disturbed and remained so for several days. Continuous baths of two hours' duration were ordered. As time went on the nurses succeeded in getting the patient interested in games and other ward recreations, thus giving him less time to indulge in his ideas of persecution. Later he became interested in reading and seemed to enjoy the company of other patients. He appeared to be less suspicious of those around him. He became well enough to go out and was given parole of the grounds and later was allowed to go into the city. The nursing of this patient consisted principally in the systematic carrying out of the continuous bath procedure including the faithful administering of the required amount of fluid during the continuous baths. An important factor also in the nursing of this patient was the nurse's ability to engage him in games sufficiently difficult to stimulate him to achievement. Her knowledge of current events combined with her conversational ability gave her the facilities to revive her patient's interest in the people and things of every day life thus applying her preparation for psychiatric nursing for his benefit.

There are practically no technicalities in psychiatric nursing, therefore, much of the success depends upon the nurse's sympathetic understanding of the patient's difficulties and her resourcefulness in devising means to avert or to meet the difficult situations as they arise, as in the case of a disturbed patient who was induced to submit to the prescribed treatment by the nurse who entered her room humming a popular air. While the patient joined in the refrain, the nurse applied the treatment, the patient cooperating in the treatment as though it were some form of amusement. Thus the probable increased disturbance of the patient's mind was avoided and many unpleasant conditions forestalled.

Another example was the aged patient from the "Emerald Isle" who was kept happy and contented by the nurse's understanding his national characteristics and appreciating his desire to retain some of the customs adhered to by many men of his age and social standing. It might appear that granting a patient the comfort of wearing a red bandana handkerchief around his head is a small matter, but in this day of effort to make everyone after a given pattern the nurse's judgment in this case was distinctly characteristic of the efficient psychiatric nurse. A nurse at all times must be understanding and defer to the patient in granting requests provided they

are harmless to him and will not interfere with the well being of others. Another example of the nurses' resourcefulness in conceiving a way out of a difficult and dangerous plight was in the case of a patient who was persuaded to hand over a weapon by the nurse's expressing a desire to be taught how to make tatting, a form of handiwork in which the patient was exceptionally proficient, while social relations were established during the lesson, the nurse seized the opportunity to ask for the weapon in rather an offhand manner, and the patient handed over the instrument without any trouble.

Although it is true that there is much that is pathetic and even tragic in the hospitals for the mentally ill, yet every now and then something occurs to relieve the seriousness of the situation. The student nurse in the mental hospital has a number of "dont's" to learn in addition to those which she has already had instilled into her during her general training. Some instances of the "don'ts" not being observed have produced embarrassing and ludicrous situations. "Don't give a feather pillow to an excited and destructive patient." A student nurse decided that this "don't" was not a matter of great importance and allowed a patient of the excited class to have such a pillow. The patient had a perfectly lovely time tearing the pillow open and shaking it vigorously with the most spectacular result. The room was full of feathers and resembled a miniature snow storm, and the patient's hair which happened to be very curly, was matted with the down. By the time the nurse had removed the down from the room and from the matted hair of the patient she fully realized the importance of that special don't.

Another don't: "Don't leave articles around which may be used for purposes other than that for which they were intended." A group of patients under the direction of a nurse were occupied in making scrap books out of picture post cards which had been collected by the nurses for the purpose of occupying the patients. A patient in the ward was greatly interested in her personal appearance, especially in the condition of her complexion and her hair, and used to have her relatives bring her all kinds of face creams and hair tonics. She decided that the library paste which had been used for pasting the post cards into the scrap book, and which the nurse had neglected to put away immeditately after using, was some kind of face cream and accordingly applied it lavishly. Only the nurse who had to remove this paste from the patient's face and hair can testify to its tenacity when applied as a cosmetic.

In our hospital work we are brought face to face with sorrow and suffering and the student nurse who has left the comforts of home to prepare herself for her life's work, and is launched into an environment so foreign to her, frequently realizes that she has assumed a heavy burden. A student who was living through her first Christmas away from home was observed on Christmas morning while attending to her ward duties to be very despondent and lonesome and she doubted her ability to persevere in a work that necessitates the giving up of home environment. Yet at the end of the day this student nurse decided that she never had known before what it was to have a real happy Christmas. She had received a box from home and had distributed its contents among the patients in her ward, being specially mindful of those who had not been remembered by their home people or who had no one to think of them on a day when thoughts turned to loved ones. In contrast to the morning the evening found this student a radiantly happy young person because she had been forgetful of self and had lived that day for the service of others.

The nurse in her busy life is brought into contact with every vicissitude of life. She sees the anxiety of the father, who, because of his illness, is not only suffering physically, but is experiencing that mental anguish that comes from his inability to earn money to provide the necessaries of life for his family. The nurse also appreciates the sorrow and anxiety of the mother who is the bread winner and has not only her suffering and weakness to contend with but has mental suffering at the thought of her little ones uncared for at home. Many nurses experience great satisfaction in belonging to a profession which requires that their days be spent in the service of others, and from both spiritual and human impulses feel specially privileged when called upon to minister to those patients who are not endowed with much of the world's goods. Nurses know the joy of seeing the patients who have been ill in the extreme recover and leave the hospital to resume their places in the world. Great as is the happiness of the nurse at seeing the physically ill restored to health, she experiences greater happiness and more complete satisfaction when she sees the mentally ill patient restored to his family and to his former place in the community.

The Jeweled Sword[1]

Judge Harold M. Stephens, Salt Lake City, Utah

There is much rivalry between professions as to which is the most useful. The soldier, urging that he protects the nation from foreign attack and internal revolt, proclaims his calling the highest—yet traitors have dishonored the profession of arms. The lawyer, thinking himself an instrument for the accomplishment of civil justice, sets the profession of law upon a pinnacle—but he, too, has dishonored it by lending his voice to an ignoble cause. The musician, the material of whose workmanship is the stuff of dreams and poetry, argues that Heaven is imaginable without paintings or statutes but not without music—yet there are fiddlers in rowdy dance halls. Doctors and nurses are given emphatically to asserting their work, since it relieves human suffering and saves life, is clearly the most useful of all.

But from the objective standpoint, it is not demonstrable that one profession or calling is more useful than another, for it is clear, upon reflection, that while each is indispensable, all are necessary one to the other and to civilized man. The true test of the utility of a calling to humankind is not the objective test, but the subjective and individual one. In short, that profession or calling is most useful which is most usefully pursued.

Doing things usefully requires both the flesh and the spirit. There is an ancient allegory about a brilliant general who demanded, in leading his troops into battle, a richly wrought and jeweled sword. It was furnished him, but in the first thrust the blade was broken, and he threw it aside and refused to proceed with the contest until a better weapon was at hand. In the meantime the troops fell into confusion, and the battle was about to be lost, when the king's son, a young man of splendid and courageous spirit, hearing at court of the impending defeat, rushed weaponless upon the battlefield, seized the broken and discarded sword of the brilliant general, and,

[1]An address to the 1926 graduates of Holy Cross Hospital, School of Nursing, Salt Lake City, Utah.

valiantly rallying the troops, fought manfully and regained the day.

It is as true in the field of nursing as upon the field of battle that the day is won less by the flesh than by the spirit. By the flesh is meant, in a broad sense of the word, the instruments of one's calling. The soldier must have his sword and his horse a saddle. So the nurse must have a healthy body, perhaps a uniform, for its disciplinary value, a steady hand, a knowledge of the technique of her calling, and of anatomy, physiology, dietetics, thermometers, and drugs. But more important than these things is her spirit, her character, her attitude towards service of humankind in the literal and effectual sense of that phrase rather than in the conventional and sentimental sense which is in our day too often given it. If she has the true spirit of the good Samaritan, she is a successful nurse, though she may have a broken sword; but without the spirit of service she is a failure, like the general with the jeweled sword.

There is complaint today about trained nurses and their profession; and that complaint, while not phrased allegorically, is, in its essence, a complaint that trained nurses will not fight unless they have a jeweled sword. It is complained that they assume the manner and aloofness of a profession; that they disdain the kitchen and the broom; that they insist upon absolute regularity of work, even in emergency, and upon a wage beyond the reach of the average of the sick. Will Mayo, one of the leading living surgeons of the world, has emphatically voiced this complaint; and the rise of the practical nurse, so-called, is some evidence of the truth of the charge. It is true that the servant is worthy of his hire, and that a nurse must make a living and therefore receive pay; and true that she must not tax her strength beyond human endurance; and true that her work, for scientific reasons, must be systematically done. These things are necessary; for the soldier must have some weapon, be it only a fist, and his horse a saddle. But where these things are given the major emphasis in the nurse's life, and the true spirit of serving suffering humankind with the hands neglected or forgotten, they constitute a jeweled sword and their bearer the proud, sulky, and defeated general.

Most human accomplishments, whether spectacular and collective, or obscure and individual, are won with a flaming spirit and a broken sword. Bunker Hill battle was won and resplendent Cornwallis and his armed and uniformed troops defeated at Yorktown by barefooted soldiers with old-fashioned guns, but in whose breasts burned the spirit of American independence. In the Northwest is a hospital equipped with every instrument of precision known to modern medicine and surgery, occupying a valuable site, its building modern and beautiful. It is a great accomplishment for the relief of human suffering and the saving of human life; but it was won with a broken sword. For when Mother Vincent Ferrier, of the Sisters of Providence of Montreal, went to Seattle in the seventies, she walked a plank, from the scow in which she came, to the native sod and the few huts which were the beginning of that now great city; and her first hospital was a hut. Most of the Catholic hospitals in America had humble beginnings and were built with broken swords; but the swords were guided by a spirit of service and sacrifice, which sought not jewels. It is indeed inevitable that all lofty human accomplishments shall be won with a broken sword, for we who win them are ourselves but broken swords. The mortal body of Christ was broken upon the cross; but through it God remade the world.

Thus, there is sounded a warning: Seek not in your calling for a jeweled sword; seek rather, the courage and the wisdom of a Florence Nightingale, and the spirit of the good Samaritan.

In conclusion, I congratulate you upon your graduation and especially upon your graduation from this hospital; for thus far in your career you have not been seeking a jeweled sword. The young nurses who waited upon me when I was here as a patient some few weeks ago had, it seemed to me, the true spirit of a nurse's calling. And by both precept and lifelong example the Sisters who have trained you have taught you the spirit of the good Samaritan and the lesson of the broken sword. So it is with hope and with confidence for the usefulness of your individual careers that I, for your hospital, say good-bye to you tonight and wish you well.

The Modern Hospital in a Small Town[1]

F. R. Carpenter, Hayden, Colo.

IT would be presumptuous of me, a layman, to theorize to you professional medical and hospital people about a modern hospital, in a small town or anywhere else, for I am almost totally unacquainted with any hospitals elsewhere than in my own home town and have never been a patient in any hospital. I can speak to you only as a dweller in what is so generally referred to in the press as the "rural districts," and testify as to what has been done in a small town of less than 600 people in the northwest corner of this state.

Work Vs. Theory

Since the time of President Roosevelt's Country Life Commission it has become an increasingly popular indoor sport, for someone who either never lived in a small town, or who has moved out of it to a larger place for more congenial surroundings, to theorize on what is the matter with the small town. Each president since that time has found it a simple matter to assemble a group of earnest and well-informed men and women to take testimony and make an enlightening report on "How to make life in the rural districts more attractive." I hope their efforts meet with some results, but it has always seemed to me that what was really needed was men and women who would stay and live in the said rural districts, and make at least one little section thereof a little more attractive.

The constant exodus of the people who do things from the small towns to the big cities is the greatest menace to the improvement of the former. What we need today is a challenge to the most ambitious and courageous of our high school and college graduates to tackle the problems of a small town; and if they did, in a short time the present indictment against the small town would be as obsolete as James Bryce's dictum about the failure of American democracy in the big cities, made thirty years ago.

What One Community Did

It is with the intent to help to make such a challenge concrete that I want to tell you the story of The Solandt Memorial Hospital at Hayden, Colorado. Situated on the western slope of the Rocky Mountains and snowbound half of the year, is a little rural town the counterpart of hundreds of others in this state—no richer and no poorer, no cleaner and no dirtier, no wetter and no drier than the average of such towns. For many years an old style pioneer physician had attended to the medical needs of the community. Day and night, winter and summer,

[1]Read at the Colorado Conference of the C. H. A.

his top buggy, his cutter with a high-built back to keep the snow off his neck, his saddle horse, or his skis, helped him to cover his territory and relieve the sick and suffering. The tales of his trips and his heroism were exceeded only by those of his cheerfulness and kindly ministering ways; and because he was a man of ideals as well as of service, he always dreamed and often talked of a hospital for Hayden. In the fall of 1916 he was killed in an automobile accident. The war came on and for three years the town and countryside were doctorless except as they availed themselves of the physician in the mining town of Mt. Harris, seven miles away, or relied on the astonishingly efficacious prescriptions and advice of the local druggist.

Difficulties Overcome

After the war, we were told in stentorian tones by every public speaker that when "the Boys" came back, either they or the folks back home, would make a drastic change for the better in living conditions. Possibly it was as the result of such a feeling that the citizens of Hayden decided that it was a mistake to live without a doctor, and that prompted them to get up a guarantee of $200 a month for a young practitioner to rely on when he opened his office. This doctor, being a recent graduate, at once agitated the matter of a hospital and recommended it not only for the service it would render, but as a means of keeping doctors in the community. The name of the loved pioneer physician suggested itself at once as a suitable one for the proposed hospital and the idea of making it a memorial to him appealed strongly to the old-timers. A dinner was given by the ladies' aid, at which the subscription list was started. The subscribers numbered over four hundred, with many subscriptions of $10 and no one subscription over $1,500. Practically every householder in the community was represented in the list of shareholders. A beautiful site overlooking the town was donated, and the work was begun.

Then there came the difficulty that arises in most such enterprises—the building costs exceeded the estimates. In fact, they exceeded the estimates by 150 per cent. At the same time hard times came on; the cattle market collapsed, banks failed, and the country was plunged into the desperate struggle for survival from which it is now just emerging. The collection of deferred installments on the subscription list became well-nigh impossible. What had been looked at as Hayden's pride, now became Hayden's white elephant in the shape of a half-finished building with vacant, staring windows. Further subscriptions became impossible, and as creditors' claims became more pressing, a loan for $12,000 was made by dividing it into twelve bonds of $1,000 each, and securing them by a first mortgage on the premises. Concrete men, plasterers, painters, carpenters, and electricians were found who would work on the building and take their pay one-half in cash and one-half in stock in the association. The merchants procured hardware and material at cost.

Thus, by a hard pull and a steady one, the building was completed. This sacrifice and work on the part of so many was a valuable means of endearing the institution to the community. The Masonic Lodge, Moose Lodge, Commercial Club, American Legion, Eastern Star, and other clubs, and certain families each undertook to furnish a room. On April 1, 1923, the building, fully equipped with operating, sterilizing, obstetrical, x-ray and doctors' dressing rooms, and two sun parlors, was thrown open for business. With an investment of $35,000, and provisions for ten beds, it seemed to many to be an overshooting of the mark for the needs of the community.

Now, it is a peculiar thing that nearly all American communities have a capacity and genius for erecting buildings. Everyone visualizes them readily and cheerfully offers to do his part; but the operation and maintenance is another story. Although by dint of much sacrifice the building had been completed and equipped, its actual use for hospital purposes still seemed an unattainable goal, particularly as the agricultural depression continued, and more and more of our citizens were losing their homes and all their savings. Some recommended using the building as a rooming house; others thought we might unload it on the county for a poorhouse; nearly all agreed that while a hospital was a good thing, it was inopportune to open it "until times got better."

The only way to get the board of directors to allow it to be opened was to underwrite any possible deficit in running expenses by persuading fifteen firms, individuals, and doctors to agree each to contribute not to exceed $10 a month if needed to break even.

Cafeteria Plan for Meals

The burning of an old established hotel in the town proved a lucky ill wind for us by providing a woman to take over the management of the hospital kitchen and dining room. The basement rooms—really a ground floor—furnished ample living rooms for her family and she ran the dining room, boarding the nurses, and providing trays for the patients somewhat in cafeteria style—that is, the hospital paying for meals as needed. Thus the expense of the kitchen to the hospital varied with the number of patients and consequently with the hospital income, and left no heavy overhead for slack times, which would have been an insuperable obstacle at the time the hospital was opened.

As further assistance in opening the institution, the town donated the water, the light company the first six months' electricity, a local mine donated coal, and the telephone company a year's telephone rental. A competent registered nurse was employed as superintendent, and the hospital began to function.

For the most part, there is nothing particularly striking or unusual about the operation of this hospital, with the exception of the management of the dining room, already described. It is open to all doctors. The head nurse is the hospital superintendent, under the authority of the board of trustees. The trustees, fifteen in number, are elected by the stockholders, with the mayor of the town and the county commissioner from this district as ex officio members. A ladies' board of twelve members looks after the linens. The trustees meet regularly once a month, and oftener if necessary. We had 105 patients the first year, 131 the second, and 162 the third. We average 80 operative cases a year and 15 babies are born there each year.

Financing Plan

We have an average deficit of $100 a month, and we take care of this each year in advance by an annual hospital ball, like the charity ball of a city. This is the big social affair of the year for Hayden, and in fact for the two counties. The music, decorations, and food are all donated, and furnished by the ladies' board. Tickets are sold at $2.50 and we find that people are glad to support the institution, as well as to attend an extra good dance. The first year the ball netted nearly $1,200 and this year over $1,400.

The charges and collections, however, are something that may strike you as unusual. We charge $25 a week for board, private room, and nursing—the same to everyone, with no exceptions, and all are required to deposit one week's charge in advance. In a country where we have almost no charity poor and where social distinctions are non-existent, and in a town without a single servant, we go on the assumption that everyone can pay a reasonable rate, or if he himself cannot, then back of him stand,

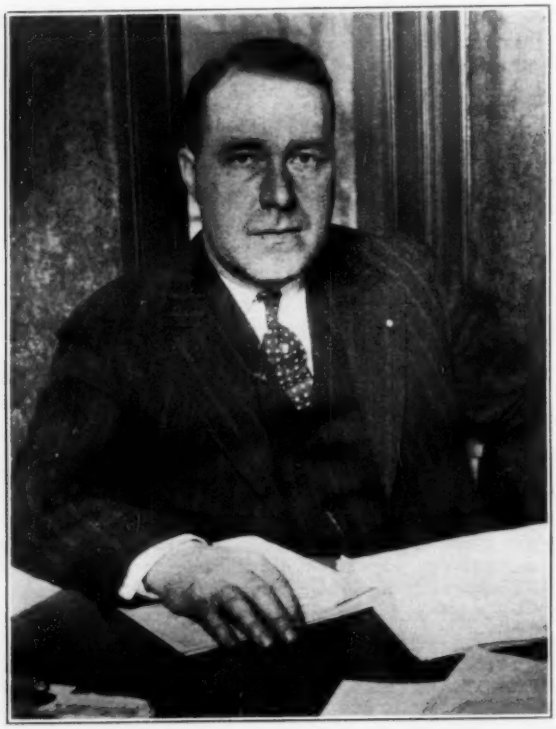
first, his family, then his friends, next his lodge or some organization to which he belongs, and as final resort, his county. So far, we have never had to put in a bill to Routt County, the county in which the hospital is situated. Moffat County has paid two bills. The first year our collections were 100 per cent and the second and third years 97.5 per cent. No part pay or charity work was done, yet no patient who needed attention was ever denied it.

The Manager's Problems

William James has said that we would never be able to do without war until we found a "moral equivalent" for it—something that evoked the same amount and quality of courage as war, and necessitated hard work, sacrifice, and close cooperation. As a difficult task to call forth one's courage in the face of discouragement, I recommend managing a hospital in a small town, where anyone who tries to hire help encounters that peculiar inertia that afflicts small town inhabitants when one wishes work done in a hurry; where you have two patients today and seventeen tomorrow, and all available extra nurses suddenly have imperative duties cleaning house or canning peaches; where the head nurse and the cook often fail to work out a line of demarcation as to their respective stations in life—a dilemma that one doctor told me could be solved only by the hospital superintendent's maxim that "head nurses are easier to get than good cooks"; where a surgeon considers a nurse's ability to assist him in the operating room the sole criterion of her value to the hospital, and when his wishes are not acceded to, takes his dolls and goes home; where lady visitors spy dirt under the radiators in an unused storeroom and publish to the town that the place is in a filthy condition; where the local drug concerns believe it is heresy of the first order to get supplies elsewhere than over their counters. These and scores more of little humorous and tragic dilemmas arise every day and must be met and smoothed out or they will assume proportions sufficient to endanger the usefulness of the institution.

DR. HUGHES APPOINTED DEAN, COLLEGE OF HOSPITAL ADMINISTRATION

Announcement was made on Dec. 9 of the appointment of Dr. John R. Hughes as dean of the college of hospital administration of Marquette University. Dr. Hughes is a former student of Marquette University and a graduate (1912) of Rush Medical College, Chicago. During the war he served in the medical corps of the army. He comes to Marquette from Dodgeville, Wis., where he was president of the staff of St. Joseph's Hospital.



JOHN R. HUGHES, M.D.,
New Dean of the College of Hospital Administration, Marquette University, Milwaukee, Wis.

Sister Silveria, Superior, St. Joseph's at Omaha, Dies

Venerable Sister Silveria, Superior of St. Joseph's Hospital, Omaha, Nebraska, since September, 1925, died at the hospital Saturday morning, November 6, 1926. Her death was due to dilatation of the heart, subsequent to appendectomy.

At the time of her death, Sister Silveria was 62 years of age. She was born at Mt. Calvary, Wisconsin; at which place she was educated by the Sisters of Notre Dame. In 1885 she entered the order of the Sisters of St. Francis. Before coming to Omaha, she was superior at Chicago Heights for six years; at Evanston, Ill., six years; and at Logansport, Indiana, for the same number of years.

SISTER SILVERIA.

Upon assuming charge at St. Joseph's Hospital in Sept., 1925, Sister Silveria mapped out and at once put into effect a wide program of improvement in hospital equipment and capacity. A part of this program remaining unfinished is the addition of two stories to the operating, x-ray, children's and obstetric departments of the hospital.

She was a Superior of rare executive ability, possessing an unusual business talent. In carrying out her plans, she evidenced a nature so gentle, so considerate of all with whom she came in contact, that she at once won the love and the esteem of the hospital personnel, the Sisters and the physicians who mourn her passing.

The funeral was held from St. Joseph's Hospital chapel on Tuesday, November 9, with Solemn Requiem High Mass, fifty priests being in attendance. The eulogy was pronounced by Rt. Rev. Francis Beckman, Bishop of Lincoln, and Apostolic administrator of the diocese of Omaha. The entire staff of doctors and nurses attended in a body. Six interns served as active pallbearers, with Sisters of St. Francis as honorary pallbearers. Interment was in Holy Sepulchre cemetery. May she rest in peace!

La Remise Des Diplomess Aux Gardes-Malades

Cérémonie à l'Hôtel-Dieu, Montreal, sous la presidence de Mgr. A.-V.-J. Piette

Monseigneur Vincent Piette, recteur de l'Université de Montréal a présidé à l'Hôtel-Dieu à la cérémonie de la collation des diplômes des gardes-malades de cette institution. Cette cérémonie coïncidait avec le 25ième anniversaire de la fondation de l'école des gardes-malades.

Les parents des nouvelles gardes et un grand nombre d'amis de l'Hôtel-Dieu assistaient à la réunion. La salle était artistiquement décorée et chaque diplômée était accompagnée d'une fillette portant une superbe gerbe de fleurs.

Apris le chant d'une cantate en l'honneur de Jeanne Mance, le docteur Réginald Savoie fit la proclamation de celles qui devaient recevoir leurs diplômes.

C'étaient: Mlles Thérèse d'Amours, Marie-Anne Marsolais, Joséphine Hébert, Jeanne d'Amours, Léonie Thuot, Anita Rolland, Anna Houle, Jeanne Rousseau, Irène Bélanger, Lucienne Descoteaux, Albertine Corriveau, Rose Jean, Marie-Thérèse Fafard, Hermance Duhamel, Rita Lachapelle et Antoinette Roy.

Mlle Fernande Bissonnette déclama avec beaucoup de feu "La Veillée" de François Coppée et les gardes Leduc et Larue chantèrent le duo extrait du "Roi d'Ys" accompagnées au piano par garde Vanasse.

Une charmante saynette composée pour la circonstance par Mlle Daveluy, intituleé "Une heure de garde" fut interprétée par garde Legendre et Mlles Fernande Bissonnette, Anita Lambert et Aurore Bigras.

Monseigneur Piette adressa ensuite quelques mots de félicitations aux religieuses et aux nouvelles gardes. "Les filles de Jeanne Mance" dit-il, "meritent tous nos égards et toute notre admiration. "Il rappela que Jeanne Mance avait été un des premiers témoins de notre histoire et qu'elle méritait l'hommage le plus ardent et le plus réfléchi. Mgr Piette déclara que la profession de garde-malade méritait toute l'attention du public. C'est pourquoi, l'Université de Montréal est heureuse par la voix de son recteur, d'offrir aux révérendes soeurs de l'Hôtel-Dieu ses hommages d'admiration et ses souhaits de prospérité et leur viendra en aide quand elles auront besoin d'elle.

Il conseilla aux gardes-malades d'être toujours fidéles à l'heure de garde et de se souvenir que le secret du bonheur réside dans la générosité et la satisfaction du devoir accompli.

Assistaient à la cérémonie: soeur Le Royer, supérieure de l'Hôtel-Dieu, les docteurs J.-E. Dubé, Donald Hingston,

[1]In response to the desire of our Canadian readers for a few articles in French, we are publishing this account of the Nurses' graduation at Hotel Dieu, Montreal, as the first of the French articles we hope to publish in HOSPITAL PROGRESS.

LE beau vieux pot de faïence qui orne la couverture de notre menu fait partie du Trésor de l'Hôtel-Dieu. Un jour, peut-être, nous saurons s'il fut apporté au pays par Jeanne Mance elle-même ou s'il arriva plus tard. Le certain, c'est qu'il constitue une très belle et très précieuse relique.

Ne point l'admirer serait manquer de goût; ne point le chérir serait manquer de cœur. Comme tel n'est pas le cas de ceux qui me lisent en ce moment, je vais me dispenser de toute effusion sentimentale ou esthétique. Mais les petites notes que voici intéresseront sans doute les amateurs de vieilles choses et les curieux de notre histoire.

La Pharmacie est aussi ancienne que l'Humanité. Depuis toujours elle a eu le souci de conserver ses précieux ingrédients en bon état. Elle a employé, pour ses récipients, les matières les plus diverses, du bois jusqu'au porphyre.

Avant nos modernes flacons en verre les apothecaires se sont servis de vases en terre cuite, émaillée ou non. Presque tous les pots de pharmacie des collectionneurs sont en faïence. Les premiers vinrent de l'Orient, puis de l'Espagne et de l'Italie. En France on les fabriqua au commencement du dix-septième siècle. Celui que j'ai photographié date certainement du grand siècle et, donc, il est aussi vénérable que notre maison.

Que contenait-il?... Son étiquette est longtemps restée mystérieuse pour moi. Le Dictionnaire des Inscriptions de Pots de Pharmacie, écrit par Dorveaux,dit bien que "Bacc.Lau" est l'abréviation du latin Baccae Lauri, mais fallait-il voir dans le signe "El" un élixir ou un électuaire?... Grosse question pour un toqué, beau probléme pour un têtu. J'ai trouvé parce que je suis l'un et l'autre.

Apprenez donc, Mesdames les Pharmaciennes, qu'il faut lire: "Electuarium "de" Baccae Lauri". Je tiens à votre disposition la formule de l'électuaire de baies de laurier, que j'ai cueillie dans une pharmacopée de l'an 1676. C'est très simple à préparer puisque, en plus du laurier, il n'y a que dix-sept autres ingrédients. A une époque oú la Thériaque renfermait encore plus de soixante matières diverses, la préparation de notre électuaire devait paraître un jeu d'enfant. Aussi Moyse Charas a-til soin de dire: "La préparation se trouvera fort facile (sic), si ayant pulvérisé les gommes dans le grand mortier de bronze parmi les autres Médicamens secs et ayant passé le tout par le tamis de soye couvert, on incorpore peu à diverses reprises cette Poudre avec trois fois autant de beau Miel écumé chaud. On serrera l'électuaire dans un pot de fayance lorsqu'il sera refroidy".

Qui sait si nos bonnes Sœurs, subitement éprises de la polypharmacie du Passé, ne vont pas s'aviser de remplir le "pot de fayance" vide depuis deux siècles? Je me hâte donc de fournir à mes confrères les indications thérapeutiques de la préparation. Elle est "fort recommandée pour le soulagement et la guérison des coliques venteuses et particulièrement de l'Iliaque". Elle est aussi "fort propre contre les difficultés d'urine et contre les passions hystériques (entendez par là: contre les douleurs utérines)." On peut la prendre par la bouche mais on s'en sert plus ordinairement pour les Clystères."

Aux historiens j'ai bien peu de choses à dire, hélas! Mais je leur signale, dans la formule, la présence du castoréum. Cette drogue coûteuse était extraite des glandes du Castor. Charas se servait parfois de castoréum canadien et il le dit dans son livre, que j'ai cité. Puisqu'on importait en France, à prix d'or, le produit du Canada, il est permis de penser qu'au Canada on avait beaucoup d'estime pour les recettes pharmaceutiques françaises oú entrait du castoréum.

Pour terminer, disons que les vases de pharmacie changeaient de nom suivant leur forme et leur affectation. Lorsquils étaient à peu près cylindriques, hauts de taille et rappelant vaguement les contours d'une pièce à feu, on les nommait: "pots à canon". Lorsqu'ils étaient ventrus, munis d'une anse et d'un bec, on les nommait: "chevrettes". Les "bouteilles" et les "cruches" se définissent elles-mêmes. Enfin, il y avait les "vases à thériaque" de forme rebondie, munis parfois de deux anses et souvent magnifiquement ornés. Ils pouvaient contenir autre chose que de la thériaque; les grandes préparations galéniques, par exemple. C'est parmi les "vases" qu'il faut placer notre cher vieux pot.

DOCTEUR LEO,
de l'Hôtel-Dieu de Montréal.

le Dr. Rolland, le Dr. Réginald Savoie, le R. P. M.-A. Lamarche, M. Garrougteight, p.s.s., M. J.-B. Clément, p.s.s., M. le chanoine A.-O. Houle, curé de Saint-Jacques de Montcalm, M. l'abbé O. Bonin, vicaire à la méme paroisse, le R. P. Eustache Gagnon, c.s.c., et un grand nombre de médecins de l'Hôtel-Dieu.

Le tout se termina par le salut du Trés-Saint-Sacrement dans la chapelle de l'Hôtel-Dieu.

Adresse de bienvenue par Mademoiselle THERESE D'AMOURS à l'occasion du vingt-cinquième anniversaire de la fondation de l'école, de l'Hôtel Dieu de Montréal

Mesdames, Mesdemoiselles,

Vous devinez à votre propre émotion, la joie qui nous anime aujourd'hui, aussi avec quel coeur bénissons-nous l'heureuse initiative de celles qui ont bien voulu vous ménager ce retour vers l'heureux passé qui fait tant de bien à nos âmes.

Répondant à l'appel de nos Mères après quelques mois d'éloignement, quelques années, un quart de siècle même pour quelques unes vous êtes revenues nombreuses, Mesdames et Mesdemoiselles, sous ce toit béni si cher à nos coeurs.

Avec quelle émotion légitime ne revoyez-vous pas ces lieux, temoins diserets le vos labeurs, de vos chagrins et quelque—fois aussi de vos joies intimes et les souvenirs se pressent en vos âmes émues. Les souvenirs: oh! Comme leur puissance évocatrice est grande et bien propre à ranimer la flamme de nos bonheurs défunts.

Si vous le voulez bien Mesdames, Mesdemoiselles, parcourons ensemble, à la faveur du souvenir, ces lieux chers à toutes et à chacune d'entre nous!

Vous retrouvez les mêmes salles de Chirurgie et de Médecine oú, craintivement d'abord, puis plus sûrement ensuite, votre main pansa tant de plaies, soulagea tant de maux, tout en versant sur les âmes le baume de la bienfaisante sympathie.

Que de doulces souvenances recèle la Salle d'Opération oú toutes petites, tremblantes parfois, vous attendiez les ordres des Grands Maîtres.

Qui de vous peut se rappeler sans un vrai plaisir le Dispensaire ou le Laboratoire. Le petit dispensaire d'alors est devenu spacieux, mais la même âme compatissante l'anime.

Vous avez fait connaissance n'est-ce pas avec notre département neuf, attendu, espéré depuis si longtemps. Tout à l'heure, vous assisterez aux agapes dans notre grand réfectoire, actuellement, c'est notre magnifique salle d'étude qui vous offre l'hospitalité, c'est ici même que nous recueillons des lèvres de nos éminents professeurs les leçons indispensables à notre culture médicale. Bien que ces lieux ne vous soient pas familiers, soyez-y chez vous quand méme, car déjà ils ont entendu parler de vous, les vaillantes des premières heures, et, comme de vieille connaissance, ils vous accueillent avec joie!

La chapelle reste la même . . . et c'est là que gardes d'aujourd'hui comme celles d'hier, s'agenouillent devant le même autel, source de joies pures comme de toutes consolations.

Ce sont tous ces souvenirs, Mesdames, qui vous ont ramenées ici et ce sont eux qui vous y accueillent. Saluez-les donc ces chers souvenirs qui parlent des heures passées, aimez-les et remerciez-les de vous rajeunir ainsi pour quelques instants en vous procurant le bonheur de sentir revivre toutes les âmes qú ici vous avez connues et aimées. J'ai nommé **"les religieuses"** qui ont fait notre école ce qu'elle est aujourd'hui; qui, suivant toujours la route tracée par Jeanne Mance, ont enseigné la divine doctrine du soulagement du pauvre et de l'infortuné! Elles ont réalisé l'oeuvre de la fondatrice, garde-malade idéale, en nous apprenant à aimer "nos malades", les membres souffrants du Christ. Quelle oeuvre sublime n'ont-el'es pas accomplie et n'accomplissent-elles pas encore et quelle profonde gratitude ne leur devons-nous pas!

Bien que quelques-unes soient disparues, elles ont dû elles aussi, il me semble, répondre à l'appel général, suivre avec le plus vif intérêt, les préparatifs de ces fêtes, et en ce moment, leurs âmes doivent être émues devant le témoignage de votre reconnaissance.

25 ans ont vécu! Le grain de sénevé est devenu un grand arbre. L'école de la première heure composée de deux ou trois gardes-malades s'est développée, grâce au concours des religieuses et des médecins dévoués qui donnérent leur temps et leur science pour le bienfait de l'Oeuvre.

Vous avez droit Mesdames, Mesdemoiselles, d'être fières de votre Alma Mater et de vous rappeler avec amour les leçons si pleines de sagésse que vous avez recues sous son toit béni. Puissions nous toutes, gardes-malades d-hier et celles d'aujourd'hui, être dignes toujours de l'institution qui nous a formées.

Il ne nous reste plus qu'à formuler des voeux pour que cette maison continue de prosperer sour la garde et la protection de Jeanne Mance; qu'elle travaille de longues années encore à la formation des jeunes infirmières, qu'elle en fasse des âmes vaillantes et chrétiennes qui iront, par le monde, soulager la misére humaine!

Et puisse cette fête de famille laisser en vos coeurs, Mesdames, Mesdemoiselles, un souvenir que vous emporterez avec vous dans la vie pour votre soutien et votre consolation!

Dans 25 ans, espérons-le, nous nous retrouverons toutes pour célébrer "les Noces d'OR" de notre Alma Mater, car si les générations passent, les institutions demeurent.

Réponse à l'adresse de bienvenue par Mme. J. P. R. Drouin (Melle. Bernadette Sénécal.)

Révérendes Soeurs, Mesdames, Mesdemoiselles,

C'est un trés grand honneur pour moi d'avoir à répondre à l'adresse si éloquente de Mdlle. Th. d'Amours. Il y aurait d'autres anciennes mieux qualifiées que moi pour vous parler; mais puisque c'est la volonté de nos chères Maîtresses que je cause avec vous quelques instants, je me rends à leur désir. Laissez-moi tout d'abord vous dire avec quel bonheur nous sommes revenues parmi vous passer quelques heures qui nous semblent bien courtes, trop courtes, et que de reconnaissance nous aurons pour celles qui ont préparé cette fête superbe qui sera l'une des plus belles de notre vie.

Oui les souvenirs sont nombreux, tristes et gaies; tristes parce que nous nous rappelons des figures amies disparues, parmi les religieuses, les docteurs et nos compagnes; les souvenirs gaies, nous revoyons nos chères maîtresses que la Providence a bien voulu nous laisser, les médecins d'hier les grands Maîtres d'aujourd'hui et nos compagnes fidèles.

Permettez-moi de vous parler un moment de nos débuts comme infirmières. L'école des gardes-malades fondée il y a vingt-cinq ans selon le désir de Monseigneur Bruchési, était composée de quelques gardes-malades, dont trois furent diplômées le 16 octobre 1903; le cours étant alors fixé à deux années. Ces trois diplômes furent Mme J. Bertrand alors Mlle E. Lefebvre, Mlle C. Howie et Mlle B. Sénécal, maintenant Mme Drouin qui a le grand plaisir de vous parler en ce moment; des examens furent passés avec grande distinction, tel que l'attestent nos diplômes. Mére Brosseau était notre supérieure, nous gardons d'elle un souvenir ému, ayant été si bonne et si dévouée pour nous. Soeur Archambault était notre directrice et je puis dire une mère pour nous. Comme dans toute oeuvre qui commence nous avons eu à traverser bien des obstacles, des épreuves; et souvent notre chére directrice nous voyant arriver les yeux rouges, le coeur gros, avec tact et douceur remontait vite notre courage et nous retournions à nos postes prêtes à accepter tous les sacrifices. Aussi, je ne puis assez vous dire toute l'affection, la reconnaissance, la tendresse que nous gardons pour celle que Dieu voudra bien conserver longtemps encore pour le bonheur de ses anciennes.

Nous avons déjà eu l'avantage d'admirer quelques-uns des nouveaux départements et votre "chez-vous". Je ne puis vous dépeindre notre surprise devant tant de comfort et je dirai même de luxe et nous en sommes si heureuses pour vous toutes. A ce propos, je vous prie de nous inviter encore chez-vous avant de célébrer vos "Noces d'Or" ce serait trop long. Serait-il possible d'organiser une Association aujourd'hui même afin de nous réunir chaque année ou plus souvent; tout en causant ou écoutant une conférence médicale, nous pourrions faire de la couture pour l'hôpital ou les pauvres.

Je suis certaine que Soeur Beaupré que nous avons toutes connue et aimée, approuverait ce projet et avec son dévouement habituel donnerait un appui puissant à l'organisation de cette oeuvre.

Suivant les traces de la glorieuse fondatrice de l'Hôtel-Dieu, Jeanne Mance, cette école doit devenir une des plus belles au Canada notre chère Patrie.

Je remercie au nom des anciennes Notre Mére dont le coeur est si grand et qui donne une si grande preuve d'attachement aux gardes-malades d'hier et celles d'aujourd'hui. Je remercie toutes les religieuses si bonnes, si compatissantes. Je remercie les médecins qui nous ont témoigné un si grand intérêt et à qui nous devons notre culture médicale. Je remercie les gardes-malades qui, par l'entremise de Garde Th. d'Amours ont parlé à notre coeur, à notre âme d'une manière si touchante. Je remercie tout le personnel de l'Hôtel-Dieu pour l'affection conservée aux anciennes.

18 mai 1926.